National HIV/AIDS Support Project (NHASP)

Milestone 95

Gender Impact Evaluation of the National HIV/AIDS Support Project of Papua New Guinea

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Acronyms

ABC	Abstain from sex (or delay first intercourse), be faithful, use Condoms
ADB	Asian Development Bank
ANU	Australian National University
BCC	Behaviour Change Communication
BCCer	Behaviour Change Communication Educator
C	Component
CBO	Community Based Organisation
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CHW	Community Health Worker
CIS	Correctional Services Institution
CSA	Child Sexual Abuse
CSEC	Commercial Sexual Exploitation of Children
CSO	Civil Society Organisation
DAC	District AIDS Committee
DWA	District Women's Association
FBO	Faith Based Organisation
FHI	Family Health International
FSVAC	Family and Sexual Violence Action Committee
FSW	Female Sex Worker
GBV	Gender Based Violence
HAMP Act	HIV/AIDS Management and Prevention Act
HBC	Home Based Care
HEO	Health Extension Officer
HRC	HIV/AIDS Response Co-ordinator
HRSC	High Risk Settings Co-ordinator
HRSS	High Risk Settings Strategy
ICRAF	Individual and Community Rights Action Foundation
IEC	Information, Education and Communication
IGWG	Interagency Gender Working Group (of USAID)
ILO	International Labour Organisation
IMR	Institute of Medical Research
INA	Institute of National Affairs
LJSP	Law and Justice Sector Programme
MDG	Millennium Development Goals
MSM	Men who have sex with men
NACS	National AIDS Council Secretariat
NCD	National Capital District
NCW	National Council of Women
NDOH	National Department of Health
NGO	Non Government Organisation
NHASP	National HIV/AIDS Support Project
NSP	National Strategic Plan
NSRRT	National Sex and Reproduction Research Team
PAC	Provincial AIDS Committee
PCC	Provincial Care Co-ordinator
PCW	Provincial Council of Women
PEP	Post Exposure Prophylaxis

PLC	Provincial Liaison Co-ordinator
PMV	Public Motor Vehicle
SCiPNG	Save the Children, PNG
SM	Syndromic Management
STI	Sexually Transmitted Infection
ToT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Organisation for Children and the Family
UNFPA	United Nations Population Fund
UNIFEM	United Nations Fund for Women
WCHP	Women and Children's Health Project
WHO	World Health Organisation
UPNG	University of PNG
VCT	Voluntary Counselling and Testing

Executive Summary

AusAID's policy on gender and development treats gender as a cross-cutting issue, to be "mainstreamed" into all its aid activities. This report was commissioned to review and assess the gender impacts of the activities of PNG's AusAID-funded National HIV/AIDS Support Programme (NHASP) and to make recommendations to guide both the Project and AusAID in future work on gender and HIV/AIDS.

The report is based on five weeks' in-country research, involving interviews and focus group discussions with key personnel of NHASP, the National AIDS Council Secretariat (NACS) the National Department of Health (NDOH), multilateral donors, national and provincial stakeholders and partners, and with other key informants, including programme implementers and beneficiaries, and persons living with HIV/AIDS; stakeholder consultations in East Sepik, Madang and Eastern Highlands provinces; review of Project documents; and a scan of published and unpublished literature.

Section 1 provides background on gender and HIV in PNG and explains why a gendered approach is essential. It describes the gender-related factors influencing the transmission, prevention and impact of HIV/AIDS among males and females at the individual, community and national levels. The specific biological, social, cultural and economic factors affecting the vulnerability to HIV/AIDS of women girls are compared to those affecting men and boys. Pervasive gender inequalities and gender based violence are shown to severely limit the ability of women and girls both to protect themselves from HIV infection, and to deal with the consequences of infection.

Section 2 reviews the gender related activities of the Project as based on the Gender Planning Framework introduced in late 2002. It assesses the impact of activities directed towards the achievement of the five targets established by the Framework. These are: a gender-sensitive working environment in country; Project advisors and partners trained to incorporate gender into planning and programming; programmes and planning address gendered power disparities and cultural norms, including gender violence, relating to HIV/AIDS; participation of women and women's organisations at all levels of planning and implementation; and active participation of women and men in trainings and workshops.

Socio-cultural and economic factors constraining the Project's gendered approach are identified, and key gender-related strengths and weaknesses are described. Strengths relate to the creation of a gender-sensitive working environment in NHASP; integration of gender, gender violence and human rights awareness into basic HIV/AIDS training for all staff and volunteers; gender issues included in STI/HIV training for health workers ; good gender balance in trainings; training of provincial women leaders to work with women in their communities; male trainers as role models; and gender-sensitive strategies for STI prevention and treatment, home-based care, and some aspects of national education and prevention campaigns.

Weaknesses include lack of sustained technical support on gender; absence of training in techniques of gender analysis and gender-sensitive planning and programming; insufficient attention given in NACS' National Strategic Plan and in provincial, district and High Risk Strategy plans and programmes to addressing the gender inequalities fuelling the epidemic; lack of sex disaggregated data in some data bases; the need for ABC messages to be supported with education and strategies designed to

enable these messages to be acted on by women; and limitations in rural outreach, peer education, surveillance and reporting, condom policy as it relates to women, and female leadership and participation in planning.

Lessons learned through the Project's activities are also described in Section 2. It was found that gender awareness training does not prepare people to do gender sensitive planning and programming, nor does it necessarily shake deeply entrenched attitudes held by women as well as men; "adding more women" is therefore not an effective strategy for increasing gender sensitivity without additional and sustained inputs of training. Integrating gender and human rights into basic HIV/AIDS training is an effective strategy for increasing gender sensitivity, as is male role modelling. The lack of sustained technical input on gender results in less effective gender programming at all levels. Overall, the Project was rated as "Satisfactory" on AusAID's Gender Impact Rating Scale.

Section 3 presents lessons learned from international experience on gender and HIV/AIDS, and discusses how AusAID can incorporate these into longer term planning. Difficulties associated with the mainstreaming approach are identified, and recommendations are made for integrating gender into the multisectoral approach to HIV/AIDS, strengthening capacity in gender in AusAID's sectoral programmes generally, gender-sensitizing the ABC approach, tackling gender based violence, involving men in transforming sexual relations, and prioritizing the empowerment of women in the education and economic sectors.

Section 4 uses the analysis offered in Section 3 to inform suggestions for strategies and activities that NHASP could undertake during the remaining life of the Project. Recommendations are made for strengthening capacity on gender and gender based violence, women's leadership, men's involvement, condom policy, surveillance and reporting, appropriate technologies, peer education and faith-based organisations. The High Risk Settings Strategy is discussed and suggestions are made for increasing gender sensitivity at policy and operational levels. Finally, proposals are made for improving the system of partner notification for HIV and STIs to increase the effectiveness of prevention efforts (especially on the transmission of HIV from mothers to babies) and to protect women and girls' from violence and further victimisation as a result of their HIV status.

Recommendations

AusAID:

2. Promote the mainstreaming of an explicitly gendered approach to HIV/AIDS in all sectoral programmes, and support this with technical and financial resources, systematic management and reporting at all levels, and the development of in-country expertise in gender analysis and gender-responsive planning and programming.
3. Raise the profile of gender as a development issue in general and as an HIV/AIDS issue in particular, and increase technical and financial resources for implementing programmes for women's empowerment across all sectors.
4. Develop further strategies (social, educational, economic and political) to enable women and girls to take greater control of their own sexuality and act on safer sex messages (ABC).
5. Take a long-term multisectoral approach to gender-based violence as an integral and explicit part of gender and HIV/AIDS mainstreaming, with a major and sustained investment in developing in-country technical expertise in gender based violence, particularly in the justice, health, education, civil society (including FBOs) economic and governance sectoral programmes.
6. Move beyond awareness-raising of gender based violence to creating an enabling environment for behaviour change by both women and men (women to protect themselves from violence, men to learn new skills and values).
7. Involve men in behaviour change strategies that are based on an understanding of cultural concepts of masculinity and the socio-economic structures that maintain them, and aim to change both, in order to create more equitable sexual relations and norms of gender identity for both sexes.
8. Prioritize strategies for empowering women and girls in the education and economic sectors.

NHASP:

2. Recruit specialist technical support on gender and HIV/AIDS to strengthen the capacity of NHASP, NACS, NDOH and other sectoral partners for planning and implementing gender sensitive programmes.
3. Set up sex-disaggregated relational databases on participation in trainings, planning and implementation workshops, and committee memberships, that will allow levels of gender balance to be tracked through time and related to type of activity and location.
4. Revise and update the "Introduction to HIV/AIDS" course to tailor the gender sessions to the PNG situation, expand the human rights session to cover the HAMP Act, and develop a plan to ensure that gender, gender based violence and human rights will remain integrated into basic HIV/AIDS training in ways that will be sustainable beyond the life of the Project.
5. Promote the reduction of gender based violence as a preventive measure against HIV/AIDS, increase the competence of NHASP, NACS, NDOH and multisectoral stakeholders at all levels to integrate responses to gender based

violence into programming, develop alliances with other donors and stakeholders, and continue to raise awareness of the issues among the general public.

6. Increase the gender sensitivity of the High Risk Settings Strategy (HRSS) at the conceptual level by redefining the strategic objective to include the partners of members of the HRSS target populations; identifying the need to go beyond safer sex messages (ABC) if women (particularly married women) and girls are to be able to practice safer sex; emphasizing gender violence as a high risk behaviour for the spread of HIV/AIDS, and egalitarian, coercion-free sexuality as a safer sex behaviour; and recognising greater gender equality as one of the pillars of an enabling environment.

7. Increase the gender sensitivity of the HRSS at the operational level by ensuring that training and programming support the ABC approach by addressing the social, cultural and economic factors which restrict women's and girls' ability to practice safer sex and highlighting the particular needs of married women; avoiding an overemphasis on females as vectors of the disease and promoting more equitable gender relations; reducing male dominance in decision-making and training; introducing programmes to reduce gender violence, in communities as well as in workplaces; adjusting BCC training to include in-depth discussion of gender issues, gender violence, and egalitarian, violence-free sexuality; and ensuring that all monitoring, evaluation and surveillance collects and analyses data by gender.

8. Develop policy, procedures and training on partner notification for STIs and HIV that take the different realities of women, men, boys and girls into account, ensuring that women are not additionally victimised by the legal requirements for partner notification under the HAMP Act; and liaise with NDOH to give priority to this issue under the new structure for Disease Control.

9. Conduct an evaluation of the effectiveness of current male and female condom distribution systems in reaching rural men and women and male and female youth, particularly in rural areas.

10. Make the promotion of women's sexual agency an explicit goal of NHASP's policy on condoms and implement strategies to achieve this, including greatly increased distribution of female condoms outside the commercial sex context.

11. Create a broad network of leaders of women's and young women's organizations from all sectors, and of women in influential positions, to be trained and resourced as advocates for promoting the protection of women and girls from HIV/AIDS, and for reducing the inequalities that prevent them from protecting themselves.

18. Strengthen men's sense of responsibility for reducing the impact of HIV/AIDS on women and children by providing role models, leadership skills and structures, promoting healthy consensual sexuality, shared parenting, and more equal gender relations.

1. Expand surveillance to provide evidence on the effectiveness or otherwise of marriage as a protective institution against HIV/AIDS for both sexes; disseminate this information to stakeholders involved in prevention and intervention particularly with women; and conduct sero-prevalence testing of young men among young men aged 15 to 24 in the general population.

2. Improve the reporting of trends in the Quarterly Statistical Reports to more accurately reflect male-female differences and the factors affecting infection in children, and provide training in gender analysis for NACS/NDOH staff analysing the data.
3. Expand the use of appropriate technologies for the care of AIDS patients in home-based and health care settings, and ensure the regular supply of basic items necessary for disease control in both.
4. Hold a conference for all stakeholders using an approach based on peer education concepts to standardize approaches and ensure that issues of gender equality, gender violence and human rights are integrated into modules used with all peer groups.
5. Provide technical support in gender to NACS and FBO stakeholders to facilitate the development of gender-sensitive responses by FBOs to HIV/AIDS.

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Annexes

1. BACKGROUND

1.1 Purpose of the Consultancy

The prime focus of the consultancy is "to provide an assessment of the differential gender impacts of the Project activities and discuss the effectiveness of gender specific activities". For full Terms of Reference, see Annex 1.

Tasks were to:

1. Review the constraints to enabling gender equity across Project activities and promoting mainstreaming of gender equity with Project partners.
2. Review Project approaches to developing gender equity in its activities.
3. Examine the Project's approaches to building women's capacity to assume leadership roles in the response.
4. Outline strengths and weaknesses of Project activity gender impacts.
5. Provide recommendations for future activities that build on progress made, and address specific areas of concern.

At the request of AusAID after the consultant's arrival in the country, it was decided that further points should be addressed:

- reference to and emphasis on lessons learnt from international best practice, rather than a focus on review alone;
- emphasis on addressing social norms and cultural practices, particularly with regard to how gender activities can be specifically designed to target men;
- scope of gender to be included as background.

1.2 Methodology

The Project's activities were assessed with reference to the gender-related output and outcome indicators provided in the reporting matrix of the Gender Planning Framework adopted by the Project in December 2002 (see Annex 2) and the medium-term impact indicators (or "targets") specified in the Gender Strategy itself (see Section 2).

Information was gathered through:

- review of Project documents, including annual plans, monitoring and evaluation reports, quarterly reports, training manuals, training reports, data bases, procedural guidelines, social mapping reports, operational plans for High Risk Settings (HRS) sites, social marketing and behaviour change campaign materials and reports, and other relevant documents;
- review of NACS key documents, including the National Strategic Plan (NSP) 2004-8 and its gender audit, the HIV/AIDS Management and Prevention (HAMP) Act, provincial and district level strategic plans;
- interviews with NHASP and NACS advisors and staff;
- interviews with Project partners, stakeholders and other key informants, including persons living with HIV/AIDS (PLWHA), and review of related documents;

- a focus group discussion of the barriers preventing women and girls from acting on ABC prevention messages, held with representatives of the eleven Provincial AIDS Committees (PACs) in the New Guinea Islands and Southern Regions ;
- evaluation of the Project's gender awareness training conducted with 20 NHASP trainers (9 males and 11 females) , and 24 trainees (16 males and 8 females);
- Provincial visits to the East Sepik, Madang and Eastern Highlands Provinces to assess provincial and district level impact through interviews with PAC staff, women's leaders, groups funded under the grants programme, HRS committee members, health staff at STI and antenatal clinics, youth theatre groups, other sexual health trainers, and NGOs collaborating with NHASP.
- scan of relevant published and unpublished literature.

A full list of persons and organizations consulted is given in Annex 3, and references are listed in Annex 4.

1.3 Status of the HIV/AIDS Epidemic in PNG

Although there are difficulties with the coverage, reliability and consistency of the data for PNG, and statistics should be interpreted with caution, all authorities agree that PNG is in the early stages of a generalized epidemic of HIV. This state was entered in 2002, when the HIV prevalence among antenatal women at PMGH passed one per cent.

In 2004, a National Consensus Workshop reviewed all available data, and estimated rates of sero-prevalence in the 15-49 year age group (i.e. the sexually active population) ranging from 0.9% to 2.5%, with a median of 1.7%.[1] Prevalence rates are higher in urban areas: between 3 and 4% in Port Moresby, over 2% in other urban areas, and over 1% percent in rural areas. But because 83% of the population is rural, the majority of infected persons (about 66%) are to be found in the rural areas. [2] This has important implications for prevention and care.

HIV can be spread in three ways: through sexual contact, from mother to child during birth or breastfeeding, or through blood. In PNG, 90% of detected cases are due to heterosexual transmission. The rest are due to mother to child transmission, and male to male sex. Injected drug use is not yet a significant factor in PNG, and transmission through blood transfusion has ceased to be an issue since the introduction of effective screening. Cross-infection in health care settings is not yet known to have occurred, though it is greatly feared by health workers, and is affecting care given to HIV positive patients.

The HIV virus was first identified in PNG in 1987. From the start, women have been infected at roughly the same rate as men. Of the 562 infections reported in the first 10 years, 48% were in women and 52% were in men.[3] In the late nineties, the virus began spreading much more rapidly, and the latest reported figures show a total of

[1] NACS and NDOH 2005, *Report of the 2004 National Consensus Workshop of PNG.* WHO and NHASP

[2] Jenkins C. 2005, *Control of HIV/AIDs in PNG: A situation assessment and proposed strategy.* Report to the World Bank, AusAID and the ADB. Draft, June.

[3] NDOH and NACS 2004, *HIV/AIDS Quarterly Report, December2004.*

1,139 reported infections, of which 46% are in females, 48% are in males, and 6% are not recorded by sex.[4]

There is a difference in the age distribution between males and females (though not as great as has sometimes been stated) with infection of females at an earlier age. Figures presented by the NDOH and NACS quarterly reports show that adolescent girls and young women in the 15-24 age group outnumber males in the same age group by two to one, but this is because most of the females are being tested when they attend for antenatal care, whereas there is no comparable routine testing for boys and young men in those age groups. Males enter the statistics either when they self-select for testing at STI clinics or VCT centres, become sick with opportunistic infections and are tested in a health care setting, or when they give blood. Since it often takes ten or more years for HIV to become symptomatic, people diagnosed in health care settings tend to be older.

High HIV prevalence rates among antenatal women, especially young mothers, are particularly disturbing, because of the risk of additional transmission to the child. In 2003, teenage mothers (15-19 years old) attending PMGH antenatal clinic had an HIV prevalence rate of 10% and of 8% in 2004.[5] Increasing numbers of children aged 2 to 9 years are testing positive for HIV, with little difference between the rates for girls and boys. Research is needed to establish to what extent mother to child transmission or sexual abuse is the mechanism of infection in these cases.

The risk of HIV transmission is greater in the presence of an STI. In Port Moresby in 2004, one fifth (19.9%) of STI patients were HIV positive.[6] PNG has extremely high rates of STIs in both males and females. The National Consensus Workshop of 2002 estimated that more than a million new cases of STIs occur in PNG annually.[7] Research by the IMR has found overall rates of STIs in the sampled populations of 40% for males and 43% for females in Kikori (Gulf Province); 34% for males and 43% for females in Moro (Southern Highlands); and 23% for males and 40% for females in Porgera (Enga).[8] Many of these people, especially women, were infected with two or three STIs at once. Of sex workers tested in Lae in 2002, 74% were found to have an STI.[9]

1.4 Why HIV/AIDS Needs a Gendered Approach

The term "gender", as defined by UNAIDS, describes the various characteristics assigned to women and men by the society in which they live. The term "sex" refers to biological characteristics. Gender is socially constructed, learned, and can vary from culture to culture, generation to generation, and over time due to societal changes. Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual, based on his or her sex.

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[4] As above.
[5] Jenkins C. 2005, *Control of HIV/AIDS in PNG: A situation assessment and proposed strategy.* Report to the World Bank, AusAID and the ADB, p2. Draft, June.
[6] NDOH and NACS 2004, *HIV/AIDS Quarterly Report, December 2004.*
[7] NACS and NDOH 2002, *Report of the 2002 National Consensus Workshop of PNG.* WHO and NHASP.
[8] Data from IMR progress report dated 24/8/04 on *HIV, Aids, STDs and Sexual Health in PNG: a multi-method, multi-sited study.* And from IMR's *HIV/STI Mapping in Selected Sites in PNG: Update.* Presentation by Tony Lupiwa at IMR's Medical Symposium, Sept 2005.
[9] IMR research cited in UNFPA 2005, *UNFPA Mission on Female Condom Programming in the Pacific: PNG,* p4. Draft, June.

An example of sexually defined roles is that women give birth to babies and breastfeed them, because only females have this biological capacity. The perception that caring for babies and small children is women's work is a gender role, because both males and females have the biological capacity to perform this role. Men are physiologically able to care for children, and if they are encouraged to do so, they may find that there are many benefits to themselves, their children and their relationships. Breaking down gender barrier or stereotypes for both men and women brings important adaptational advantages for a society, especially one, such as PNG, in the midst of rapid social change.

Gender is the primary organizing principle of all human societies. Children are treated differently according to their gender even in infancy, and are taught what is expected of "good" men and women from a very early age. Gender conditioning therefore runs very deep and is difficult to change. This is especially so when people believe that gender roles are biologically fixed, or when the system of gender relations is highly unequal and one sex (usually men) enjoys considerably more privileges and advantages than the other. In PNG, both these conditions apply.

In the context of HIV/AIDS, gender is a major factor determining:

- an individual's risk of contracting HIV;
- an individual's access to diagnosis, care and treatment for HIV/AIDS;
- the consequences to the individual of being diagnosed with HIV;
- the progress of the illness;
- the impact of an individual's HIV-related illness and death on their family and community; and
- the socio-economic consequences for the country.

The factors affecting HIV/AIDS infection in men and women differ, reflecting differences in biology, sexual behaviour, social attitudes, and power imbalances. Differences in attitudes to men's and women's sexuality condone men's involvement in risky, often violent, sex with multiple partners, while requiring women to be submissive even to unfaithful partners. Inequality between the sexes restricts women's access to care and services. It also limits both men and women's opportunities to inform themselves about safer sexual practices, and improve their capacity to protect themselves from HIV. These factors will be described in more detail in Sections 1.5 and 1.6.

Gender also is a major determinant of the consequences of HIV/AIDS for individuals, families, communities and the wider society. It is women's daily work that feeds rural families, and their other many roles hold the family and the community together. The burden of caring will fall disproportionately on women and girls. In a NHASP commissioned study of dying with AIDS in villages in the Daulo district of the Eastern Highlands Province all except one carer were women. The increased labour involved in carrying water to keep the sick person clean (especially in the diarrhoeal stage), and in meeting all the needs of the household, means less time for women and girls to work in food gardens, or conduct economic activities, increasing economic hardship for the family. A Tanzanian study found that when there was a person sick with AIDS in the household, between one-third and one half of women's time was

spent on caring for that person.[10] Care of orphans will also greatly increase women's workload as the epidemic progresses. It is estimated that there will be 77,000 AIDS orphans in PNG by 2010, and another 270,000 children living in AIDS-affected families who are at risk of being orphaned[11].

Girls are often withdrawn from school to help with domestic chores, which limits their future life choices. Younger children are less well cared for, increasing their risk of sexual abuse, and less well fed. Since 30% of under-5s are already malnourished, children's physical and mental development could become seriously retarded.[12] One answer, as has been found in Africa, is to increase the involvement of men and boys both in care-giving and in growing food for the family.[13]

A person's experience of HIV/AIDS is affected by his or her gender. When a man gets sick with AIDS, he is cared for by his wife. Women known to have HIV/AIDS are more likely to be rejected by their family, denied treatment, care and basic human rights. Many instances were cited during the consultations for this report of women being thrown out, abandoned in garden huts, burned, drowned or otherwise murdered, and substantiated in the literature.[14] Men, too, may be victimised, but they are less vulnerable. A similar situation exists in hospitals, where more women than men are abandoned in the ward once it is known they have AIDS.[15] As one Highlands health worker said: "Women don't count for much in this culture, so if a woman gets AIDS, they just throw her away".

Women are often diagnosed at a later stage of infection than are men, because the progress of the disease is different, and because it is harder for them to attend health services.[16] The first signs of HIV infection in women tend to be gynaecological in natures, and are often mistaken for less serious conditions. By the time they are diagnosed, their health may have declined too far to benefit from medical care. STIs in women greatly increase their risk of HIV infection, but are often asymptomatic in women. Malnutrition and heavy workloads may also weaken women's immune systems and lessen their resistance to opportunistic infections. The National Health Plan predicts that massively increasing demands on the health care system by AIDS patients will mean existing health services, including maternal and child health care, will decline without vast injections of new funds.[17]

The economic consequences of HIV/AIDS infection are more severe for women because of their dependence on men. Women have much less access to cash than men, so if a husband becomes sick, the only way to replace the lost income may be for the wife (or children) to sell sex. If the husband dies, his widow does not necessarily have automatic rights to stay on the land in patrilineal societies, but she may also not be

[10] The Global Coalition on Women and AIDS 2003, *Care, Women and AIDS Backgrounder.* www.womenandaids.org

[11] UNICEF 2005, *Families and Children Affected by HIV/AIDS and Other Vulnerable Children in PNG*, p39. Draft, March.

[12] As above, p 31.

[13] As above, p32.

[14] Hammar L. 2005, *Fear and Loathing in PNG: sexual behaviour and sexual health amidst AIDS anxiety.* Paper presented at a Working Session on AIDS in Oceania, Association for Social Anthropology in Oceania.
UNICEF 2005, as above p20, cites anthropological reports of extreme brutality to HIV positive women in the Southern Highlands, including torture resulting in death.

[15] From discussions with medical ward staff in Goroka Base and Madang's Modilon hospitals.

[16] WHO 2003, *Integrating Gender into HIV/AIDS Programmes: A Review Paper,* p 19.

[17] NDOH 2001, *PNG National Health Plan 2001-2010*, p 123-4.

accepted back in her home village. A recent study in PNG has found that "female headed households are several times more likely to be below the absolute poverty line". [18]

In terms of the gendered impact on the national economy, infection in men will have more effect on the formal economy and the labour market, whereas infection in women will have more effect on the informal economy and food production. Up to three quarters of people infected live in rural areas.[19] An AusAID-sponsored study has projected that the impact on women and children at the household level will reduce production in subsistence agriculture by one quarter.[20] At national level, this could have serious implications for food security and political stability.

In the formal economy, where the workforce is mostly male, HIV/AIDS will result in a loss of skilled and professional workers, a decline in productivity, and an increase in the cost of doing business through faster turnover of personnel and the need for more sustained investment in training. PNG's dependency ratio – the proportion of dependents to income-earners – is already high, at 80%, and is expected to rise as the epidemic worsens, throwing more households into absolute poverty. [21] The ability of government to continue to fund non-productive programmes in the health, education, law and justice and social sectors will decline.

Experience in Africa suggests that progress towards gender equity will be slowed as the epidemic worsens.[22] Increasing stress and poverty will exacerbate already apalling rates of physical and sexual violence and the sexual abuse and exploitation of children, with women falling further and further behind men in education, employment, and political participation. This is a frightening prospect for PNG's women and girls, and for the development of the country overall.

As these examples have shown, gender differences and inequalities greatly affect how HIV/AIDS is spread, and the impact that it has on individuals, families, communities and the country as a whole. Effective prevention and interventions for HIV/AIDS must be based on this reality. "People" is not a meaningful category for planning an HIV/AIDS response at any level, because men and women lead such different lives. Planning for HIV/AIDS without a focus on gender is like looking with one eye closed. Looking through a gender lens gives us the whole picture, and produces more wholistic and effective solutions. This has been demonstrated by research around the world.[23]

1.5 Factors Affecting Women's and Girls' Vulnerability to HIV/AIDS

Biological factors play some part in the vulnerability of women and girls to HIV/AIDS, but factors relating to gender-based social, cultural and economic inequalities are far more decisive.

[18] Centre for International Economics 2002 , *Potential economic impacts of an HIV/AIDS epidemic in PNG,* p 70. Report to AusAID, February.
[19] Jenkins C. 2005, p 17
[20] Centre for International Economics 2002, p xiii..
[21] As above, p 69.
[22] UNICEF 2005, p 32.
[23] WHO 2003, *Integrating Gender into HIV/AIDS Programmes: A Review Paper,* p 7.
IGWG 2005, *The 'So What?'Report: A Look at Whether Integrating a Gender Focus into Programmes Makes a Difference to Outcomes (Summary version).* http://www.igwg.org

Biological factors:

Females are at greater risk of infection by STIs than males, and are up to four times as likely to contract HIV from unprotected vaginal intercourse.[24] This is because in females, the vagina and cervix present a larger surface area for the entrance of viruses or bacteria through lesions or breaks in the mucosal lining, and because there is a higher concentration of the HIV virus in semen than in vaginal fluids.[25]

Male-to-female transmission of both STIs and HIV therefore happens more easily than female-to-male, especially if intercourse is rough or forced. Younger women are at greater biological risk because their immature cervix and scant vaginal secretions put up less of a barrier to HIV, and because their tissues are more easily damaged by intercourse. Older women also become more vulnerable again after the menopause, with the lessening of hormone-induced vaginal secretions.

Social, cultural and economic factors:

Women in PNG are disadvantaged in relation to men, and in relation to women in other countries, in many significant aspects of their lives. The national censuses of 1980 and 1990 found that men had a higher life expectancy than women (54.6 yrs and 53.5 yrs in 1980, 52.2 yrs and 51.4 yrs for in 1990), a condition that occurs in only a small number of countries in the world marked by poverty and low status of women.[26] The census of 2000 showed a small reversal in this trend (men 53.7 yrs, women 54.6 yrs), but the gap remains disturbing.[27] PNG's rate of maternal mortality is nearly double that of any other country in the Pacific region, at 300 per 100,000 live births.[28]

PNG ranks 103rd out of 177 countries rated on the UNDP's Gender-related Development Index (GDI), a composite measuring indicators relating to life expectancy, health, knowledge and standard of living.[29] Half of PNG's adult women are not functionally literate, compared to one-third of men.[30] Enrolment of girls in primary education is 69 per 100, the lowest in the Pacific region. For boys, the figures are 79 per 100, and the gap increases with each higher grade.[31] At national level, women's rates of political participation are among the lowest in the world. Currently, PNG has only one female member of Parliament (out of a total of 109), and only four women have ever been elected to Parliament. This puts PNG third from bottom of an international ranking of 121 countries, in 119th place.[32]

Male dominance in public life: All PNG traditional cultures are based on a strongly gendered division of roles and responsibilities. Traditionally, leadership has always been the prerogative of men, and women have had little or no role in decision-making in other than domestic matters, and often not even then. There are only a few cultures

[24] Population Reference Bureau 2006, *The Global Challenge of HIV and AIDS,* Population Bulletin Vol. 61, No. 1, March, p5.
[25] UNDP 2001, *Women, Gender and HIV/AIDS in East and Southeast Asia Information Kit.* Bangkok, UNDP.
[26] NHASP 2002, *Milestone 36, Gender Planning Framework*, p6.
[27] Schoeffel P., 2004, *Pacific Strategy 2005-2009: Gender Strategy for the Pacific.* ADB, p15.
[28] ADB MDGs Online Report, 2005, www.adb.org/documents/book/key.indicators/2005/default.asp
[29] http//:hdr.undp.org/statistics/data/countries
[30] As above, figures for 2003, latest year available.
[31] Figures for 2002, latest year available, in the ADB's On-line Report on the MDGs, at www.adb.org
[32] As above, p20.

with inherited positions of power. In most cultures, power was earned through prominence in ritual exchange ceremonies or warfare, or through skill in alliance building. Control of women and their labour was an important factor in attaining power. This association of men with leadership and decision-making in public life has continued in modern times. Women and their interests remain under-represented in all public institutions at decision-making levels, including in faith-based organisations.

Male dominance in the justice sector is a major means by which men maintain control of women. Under national law and the Constitution, women have equal rights to divorce, custody of children, a share in marital property, and protection from physical and sexual abuse including in marriage, but the complexities and male bias of the national legal system, and police apathy or outright brutality, prevent women from exercising their rights.[33] In village courts women fare even worse, because these courts follow customary law and commonly punish women for marital disobedience. In the context of HIV/AIDS, with the perception of women as "vectors of infection" and the pervasive suspicion of women, particularly in the Highlands, it is highly likely that men infected by HIV will use the village courts to demand punitive compensation payments from wives.

Male dominance in marriage: Within marriage, men's control of women is often justified by the payment of brideprice. This tradition is still practiced in most parts of PNG, though many complain that it has become more of a "bisnis", and another way for men to exploit women. Brideprice traditionally legitimates the transfer to the husband of full rights to his wife's sexual and reproductive labour. The wife's earnings belong to her husband (though customarily, women are allowed to keep profits from the sale of garden produce). In patrilineal systems, brideprice usually also entitles a man to full custody of all children born to his wife. If she leaves the marriage, she must leave the children behind. This is a powerful incentive for women to put up with abusive treatment. Women are expected to bear children, otherwise the husband can demand the return of the brideprice. Condom use is therefore not an option for many married women.

Christianity, too, supports men's control over women in marriage, prescribing that a man should be head of the family as Christ is head of the church. The proliferation of fundamentalist sects strengthens this attitude, and the expectation of female submission.

Despite Christian influence, polygamy is still practiced, particularly in the Highlands. The last Demographic and Health Survey (1996) found that 14.2% of women lived in polygamous marriages, with 9.3% of women having one other co-wife, and 4.6% having two or more. Polygamy is very unpopular with women, and the murder of a second wife by a first wife is the most common murder committed by women. [34]

Male dominance in sexual relations: There is a double standard in sexual behaviour which increases the vulnerability of women and girls to HIV/AIDS. Fidelity to one sexual partner is both the ideal and statistical norm for women, but not for men. In a study of rural and periurban men and women, 71% of men reported extramarital sex, with 19% having had over 5 extramarital partners; over half the men married to a single wife had had other partners during the previous year. Only 21% of women had

[33] LJSP Programme Design Document, and related gender papers.
[34] NHASP 2002, *Milestone 36*, *Gender Planning Framework,* p6.

ever had an extramarital partner.[35] Girls are expected to be virgins when they marry, and lower brideprice is paid for girls who are known not to be, but there are no such restrictions on young men. Through fear of pregnancy, unmarried girls may agree to anal sex, which increases their risk of HIV.

Women and girls are taught to leave the initiative and decision-making in sex to males, whose needs and demands are expected to dominate. This makes it difficult for women, and particularly girls, to access or use condoms and safe sex information. Condoms are still associated with promiscuity, and sex work, and carrying or using a condom, or appearing too knowledgeable about other sexual practices, can result in violence or rejection for females who are not openly engaged in sex work. Low levels of functional literacy and Christian religious influences also impact on women's access to information, and on their perception of their own risk within the context of marriage.

Traditionally, girls were married at an early age, soon after puberty. Christian influences and laws against sex with minors have encouraged later marriage, but there are many reports that older men are seeking sex, and/or marriage, with very young girls, as a way of avoiding the risk of HIV to themselves.[36] However, since these older men may well be already infected, the risk to young girls is much greater. Evidence from South Africa suggests that young women who have partners older than them (by more than 3 years) have 1.6 higher odds of being infected with HIV than young women whose partners are closer in age.[37]

Women's workload and health: The heavy workload of women, particularly rural women, is a factor in female vulnerability to HIV/AIDS. PNG women have the highest participation in agricultural labour of any Pacific country, at 84%.[38] In rural PNG, it is women, not men, who are responsible for putting food "on the table". They carry out all the regular work of domestic food production (men being responsible only for initial clearing of land and occasional other tasks). In addition, they often are required to perform much of the work for cash crop production, which is controlled by males. As well, they spend many hours a day fetching water and firewood, and in other female tasks of preparing and cooking food, washing clothes, caring for children, the elderly and the sick, and many other domestic chores, often while pregnant, or breastfeeding. As already mentioned, maternal mortality is very high.

As a result, rural women's health and immune systems can be compromised by exhaustion. This can be compounded by malnutrition and anaemia, caused in part by customary food distribution practices that in some areas reserve the best foods for men and boys, or require women and girls to eat last. Women often do not get the health care they need because they are prevented by their burden of work, or because of male-imposed constraints on their mobility. Many pregnancies and long periods of breastfeeding (up to two years) also have a negative impact on women's health.

Women's economic disadvantage: Women's lower levels of education, lesser access to wage employment or income earning opportunities and exclusion from land ownership and property rights mean that they are dependent on males for their means

[35] Reported in Jenkins C. 2005, *Control of HIV/AIDS in Papua New Guinea: A situation assessment and proposed strategy.* The World Bank, AusAID and the ADB, p 7.
[36] NHASP 2005, *Milestone 83*: *Social Mapping Summary Report.*
[37] Reported in The Global Coalition on Women and AIDS and WHO, 2004, *Violence Against Women and HIV/AIDS: Critical Intersections.* www.who.int/gender/violence/en/vaw/informationbrief.pdf
[38] Schoeffel P. 2004, *Pacific Strategy 2005-2009: Gender Strategy for the Pacific.* ADB, p 7.

of livelihood. This reduces their ability to negotiate safer sex, to confront or to leave a partner who puts them (or their children) at risk, to access medical treatment without male permission or to pay for it and the transport to get there, or to seek out information about how to protect themselves from HIV.

Most land is held by patrilineal clans, in which land passes through the male line to males. Females have use rights while single, but once married, they move to their husband's clan and have use rights there, as long as the marriage lasts. Deserted, separated or divorced wives, and often widows, may be sent home, where they cannot count on being provided with garden land. As a result they can face extreme poverty and hardship. This is particularly so in the Highlands provinces, where there has been a rapid increase in population leading to shortage of land.[39]

Even in matrilineal societies, found in some of PNG's islands, women are disadvantaged in terms of land rights. Rights to land pass through the female line, but control remains with men. A woman moves to live on her husband's land at marriage. On his death, everything is inherited by the children of his sisters, and the wife and her children must return home with nothing. Only in some societies in Bougainville, where the woman stays on the land and her husband moves to live there with her, do women retain equal rights and control of land.

Commercial and transactional sex: Social mapping conducted in 19 provinces by NHASP and numerous other studies over the last dozen years reveal high rates of commercial and transactional sex, even in rural areas.[40] Transactional sex refers to situations where there is an exchange of cash, goods or favours in return for sex. The line between this, and commercial sex conducted by people (mostly women and girls) who support themselves mainly or wholly by sex, is a fine one. The thread linking them is economic necessity.

In every province, villagers interviewed during the social mapping exercise commented that because of poverty and lack of employment options, both married and unmarried women have turned to offering sex in return for what they need or want. This may be "a ticket to the local video house, betel nuts, money for gambling or school fees, or food for their families".[41] These women were not necessarily stigmatised as "sex workers", though most tried to hide their activities to varying degrees. However, girls and young women are often criticised for using sex to get "non-essential" items such as fashionable clothes, or entry to places of entertainment, which men have the money to purchase for themselves.

In rural communities around economic development enclaves (e.g. mines, logging camps, fish plants, oil palm plantations) and road and bridge construction sites, there are many opportunities for women and girls to sell sex to men. Wherever there are good roads and regular traffic, too, women in rural areas are able to exchange sex for what they need. The Highlands Highway running from Porgera mine site in Enga, through the Highlands provinces to the ports of Lae, is a major site for high-risk sex behaviours, throughout its 600 km length.

[39] NHASP 2005 Milestone 83, *Social Mapping Summary Report*, p16.
[40] NHASP 2005 Milestone 83, *Social Mapping Summary Report*, and numerous studies cited in Jenkins C. 2005,C*ontrol of HIV/AIDS in Papua New Guinea: A situation assessment and proposed strategy.* The World Bank, AusAID and the ADB.
[41] NHASP Milestone 83, p20.

Other rural locations where transactional sex takes place are markets, "six-to-six" village discos, village video houses, and bingo and card gambling places. Any social occasion drawing many people together can also offer the opportunity for sexual transactions, such as sporting competitions, bride-price and mourning ceremonies, traditional feasts, and even church-sponsored events such as Easter celebrations, crusades and night fellowships.[42]

In the vicinity of towns, the greater the need for cash, and the higher the rate of transactional sex, even among young girls. NCD's social mapping exercise found that selling sex is very common "in all kinds of living area, residential, settlements and rural villages", "from young women, married women, divorced and widowed women, to young school girls and boys who sell sex to meet their economic and financial needs".

There were many reports of girls and young women, and even some boys, being pressured by parents and families in many parts of the country to contribute money to the family, and being forced to sell sex to get it.[43] Social mapping recorded many instances around the country of husbands forcing their wives to sell sex for money, or provide sexual favours to other males for benefit to the husband (e.g. to a magistrate, to influence a court decision), or to obtain cartons of beer for drinking parties.

Women identifying themselves as commercial sex workers are more likely to be found in urban areas and around large-scale economic development enclaves. A recent study of sex workers in Port Moresby and Goroka found that most female sex workers had been married but were now divorced or separated from their husbands, and had started selling sex shortly after their marriage ended.[44] The majority were living with their families, and were financially supporting many other people (parents, children, relatives). Most had only a primary school education, or less. In Port Moresby, 19% were under 20 years old, and in Goroka, 12%. In the past twelve months, two-thirds had been both raped and physically assaulted, and/or showed symptoms of an STI. Of the younger sex workers, most had run away from home as a result of being raped, or to escape sexual abuse by a step-father.[45]

Between commercial sex workers and women who have transactional sex, there is a key difference that affects their vulnerability to HIV/AIDS. Commercial sex workers generally recognise their risks, and are being reached by targeted interventions (eg by the Transex Project of the late nineties, World Vision, the Poro Sapot Project, NHASP's HRSS, the YWCA, and by many other NGOs and CBOs). Women engaged in transactional sex, however, especially rural women and girls, are much harder to identify and to reach with programmes to assist them to reduce their risks. Few NGOs working on HIV/AIDS seem to be aware how common this practice has become in PNG.[46]

[42] As above, p18

[43] UNICEF and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG.* Draft, January. And: UNICEF 2005, *Families and Children Affected by HIV/AIDS and other Vulnerable Children in PNG: A National Situation Analysis.* Draft, March.

[44] FHI, IMR and SCiPNG 2005, *Quantitative Study Results among FSWs in Port Moresby and Goroka*, slide presentation.

[45] GoPNG and UNICEF 1999, *PNG's Initial Report to the UN Committee on the Rights of the Child, p* 93.

[46] NHASP 2005 Milestone 83, *Social Summary Report*, p 20.

Violence against women and children: Physical and sexual violence against women and children, (particularly girls), in PNG is extreme. As well as greatly increasing their vulnerability to HIV infection through forced sex, the fear and the real risk of violence impact on virtually every aspect of women's lives, perpetuating male control and severely limiting women's options.

Research conducted by the PNG Law Reform Commission among 1,191 men and 1,203 women throughout the country found that domestic violence is a fact of life for two-thirds of PNG's women as a national average.[47] In parts of the Highlands, the rates are close to 100%. In urban areas, the violence was severe enough that one in six of all wives interviewed (not just of those reportedly hit) had needed medical treatment for their injuries. Physical abuse is commonly accompanied by emotional, social and economic abuse, which erode women's self-confidence and further limit their capacity to help themselves.[48]

Domestic violence, also known as intimate partner violence, has been identified as a risk factor for HIV/AIDS. Studies in three African countries have found up to three-fold increases in risk of HIV among women who have experienced violence compared to those who have not.[49] A study from India found that abusive men were more likely to engage in extramarital sex, acquire an STI, and place their wives at higher risk of HIV, possibly through sexual abuse.[50] In African studies, fear of violence has been found to severely affect women's ability to be tested, obtain treatment, or disclose an HIV positive diagnosis. Although not yet formally studied in PNG, similar observations were frequently mentioned by persons interviewed for this report.

Much domestic violence involves forced sex (marital rape), a finding also supported by a national study of sexual behaviour conducted by the IMR, where half the married women interviewed said they had been forced into sex by husbands, either by beating or by threats.[51] Outside the family, rape and gang rape have reached the point where many women live in a state of fear, especially in towns and areas of tribal fighting. [52] Rape has been described as being at "epidemic levels", and a "major threat to social stability and economic development".[53] Social mapping reported rape and gang rape of young girls, young women and older women in all parts of PNG.[54]

Women and girls are also frequently harassed sexually, even raped, by persons in authority such as teachers and employers, and by those they turn to for help in crisis – police, defence force, and rescue workers in disaster and conflict zones.[55] The police are notorious for holding frequent line-ups with sex-workers [56], as are the defence

[47] PNG Law Reform Commission 1992, *Final Report on Domestic Violence.* Report No. 14.
[48] Bradley C. 2001, *Family and Sexual Violence in PNG: An Integrated Long-Term Strategy,* p 7-10. INA Discussion Paper No. 84, Port Moresby.
[49] Reported in The Global Coalition on Women and AIDS and WHO, 2004, *Violence Against Women and HIV/AIDS: Critical Intersections.*
[50] As above.
[51] NSRRT and Jenkins C. 1994, *National Study of Sexual and Reproductive Knowledge and Behaviour in PNG.* IMR Monograph No. 10.
[52] Bradley C. 2001, p iv.
[53] UNICEf and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG.* Draft, p 15.
[54] NHASP 2005, *Milestone 83,*p 15.
[55] GOPNG and UNICEF 1999, *PNG's Initial Report to the UN Committee of the Rights of the Child,* p 85.
[56] Reported in Reported in Jenkins C. 2005, *Control of HIV/AIDS in Papua New Guinea: A situation assessment and proposed strategy.* The World Bank, AusAID and the ADB

force with sex-workers and other coerced women and girls.[57] Tribal fighting in parts of the Highlands has caused a breakdown in law and order and increase in rape and gang rape, to the point where many girls cannot safely attend school. [58]

Sexual abuse of children is an increasingly alarming problem. A study at PMGH in 1985 found that 47.6% of victims of sexual assault were under 16 years old, and 13.4% were under 8 years old.[59] A study at Lae's Angau Hospital during 2000 found that one third of cases were against girls under 16 years old, with five cases against girls less than 5 years old. At Goroka Base Hospital in 2000, 53% of rape victims seen in a six month period were aged under 16 years, with 3 cases of three year olds. [60] PNG's Report on the Convention on the Rights of the Child found that police records for 1991-6 showed that half of all victims filing cases of sexual assault were under 15 years old. [61]

A recent study on child sexual abuse and child sexual exploitation by UNICEF and HELP Resources describes many traditional cultural practices involving sexual activity, both heterosexual and homosexual, between adults and children.[62] Modern conditions have increased children's exposure to sexual abuse from both strangers and family members, especially in towns, where overcrowding, high turnover of household members, financial pressures that prevent parents from supervising their children, and lack of awareness of risk make children vulnerable. The study also identifies numerous forms of commercial sexual exploitation of children, such as the sale of babies, infants and child brides, forcing children to sell sex to support the family, parents using their own houses as venues for commercial sex and victimising their own children, and the selling of underage girls into employment.

Studies in other countries have found that sexual abuse during childhood and forced sexual initiation during adolescence are associated with increased HIV risk-taking.[63] Risk behaviours identified are earlier sexual debut, higher number of sexual partners, anal sex, sex with unfamiliar partners, low condom use and entry into the sex trade. PNG's demographics are such that sexual abuse of children has extremely serious consequences for the spread of HIV/AIDS, with 49% of the population being under 18 years old.[64]

Of serious concern is the extent to which violence against women (less so against children) is accepted and tolerated. Although identified as a major problem in the social mapping studies, and in many other reports, including NHASP and NACS documents, there has been very little action taken to reduce it. The perception amongst PNG communities seems to be that violence against women is a regrettable

[57] Pantumari J and Baume P. 2002, *A Perception of Factors Associated with HIV/AIDS Infection Among Soldiers in Port Moresby, PNG.* Thesis submitted for MHP, School of Medical and Social Science, UPNG.
[58] Kup Women for Peace, Newsletter, March 2005, and Meri Kirap Sapotim newsletters.
[59] Riley et al. 1985, *The Management of Rape and Other Sexual Offences in Port Moresby: Report of a Workshop Held on 4th June 1985., p 3.*
[60] Bradley C. Bradley C. 2001, *Family and Sexual Violence in PNG: an Integrated Long Term Strategy.* INA Discussion Paper No. 84., p 16.
[61] GOPNG and UNICEF 1999, *PNG's Initial Report to the UN Committee on the Rights of the Child,* p94.
[62] UNICEf and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG.* Draft January 05, p 15.
[63] Heise L. et al 1999, *Population Reports: Ending Violence Against Women,* p 15.
[64] GOPNG 2004, *Papua New Guinea: UN Secretary General's Study on Violence Against Children,* p 2.

but inevitable aspect of human life, too entrenched to change. This attitude must be addressed in programming.

1.6 Factors Affecting Men's and Boys' Vulnerability to HIV/AIDS

Although the HIV/AIDS epidemic in PNG is becoming increasingly feminised, it is vital to understand the factors affecting the vulnerability of men and boys to HIV/AIDS. Men are still the dominant decision-makers in PNG society at all levels, and particularly so in sexual relations. Attitudes and practices which put men at risk also put at risk the women and girls with whom they have sex. All over the world, men have more sexual partners than women, and a man with HIV is therefore likely to infect more people over a lifetime than is woman with HIV.[65] Yet men's behaviour is to some extent shaped by cultural, social and economic factors beyond their control.

Masculinity and risk behaviours: Males in PNG are socialised from an early age to be physically strong, emotionally unyielding, adventurous, aggressive and violent when necessary, sexually active, knowledgeable about sex, and dominant over women. In former times, when a community's survival might depend on the strength of its warriors or the endurance of its hunters and sea-going fishermen, these qualities had adaptational advantages. In modern times, they can propel men into risk-taking behaviours than put them at risk of contracting HIV/AIDS. Examples are alcohol and marijuana abuse, aggressive and violent sexuality including gang rape, opportunistic sex, low condom use, scarification, circumcision, and a fashion for inserting objects into the skin of the penis for extra sexual stimulation.

The expectation that men should be sexually knowledgeable makes it difficult for men who would like to know more about condom use and other safer sexual practices to openly admit what they need. Embarrassment, difficulty in finding or paying for condoms, the belief that condoms reduce sensation during sex, and fears of a potent kind of sorcery which can be done using a person's bodily secretions, such as semen in a used condom, all contribute to men's low use of condoms and vulnerability to HIV/AIDS. A recent survey found that even after four years of aggressive social marketing of condoms, 40% of urban or peri-urban men had never used a condom.[66]

Violent sexuality: The association of violence against women with masculine identity, belief in the uncontrollability of male sexual urges, and men's sense of entitlement over women are the key motivators for sexual violence against women. In recent years, some commentators have suggested that a major function of rape, and particularly gang rape, is to strengthen male bonding through the domination of women and to partially compensate for their powerlessness in other areas of life.[67] These issues are further discussed in Section 3.5.

All forms of rape increase men's (as well as women's) risk of contracting HIV, but gang rape is the most dangerous, since men can contract HIV not only from their victim, but also from the semen of other men ahead of them in the "line-up". In the national study of sexual behaviour, 60% of men interviewed reported having participated in a gang rape, (known as line-ups), at some time in their lives, involving

[65] UNAIDS 2000, *Men and AIDS – a Gendered Approach: 2000 World AIDS Campaign.*
[66] Marketsearch 2005, *National HIV/AIDS Support Project Social Marketing Campaign Phase 4 Evaluation, Quantitative Research Report.* p42. March .
[67] NSRRT and Jenkins C. 1994, *National Study of Sexual and Reproductive Knowledge and Behaviour in PNG.* IMR Monograph No. 10, p 102.

an average of ten men at a time.[68] In a study of 82 male youth, 31% of males had participated in gang rape, the majority of them numerous times. Forty per cent had forced women to have sex when acting alone. Another study of youth found that 24% of males admitted to taking part in line-ups, and a 1997 study of police found that 10% had participated in a line-up in the previous week.[69] Focus group discussions with soldiers revealed that line-ups with sex workers or coerced girls were a very regular occurrence in the barracks.[70]

Multiple partners: The ability to have more than one wife was a traditional status symbol for men in traditional times that has survived, and even increased, in today's conditions. Traditionally, this was justified by the taboos on sex with a wife while she was pregnant or breastfeeding, which could require abstinence of three or more years per child. Nowadays these taboos have largely fallen away, yet men continue to have multiple wives, as well as multiple extramarital partners, as was described in the previous section.

Payment for sex with casual partners is also extremely common. A nationwide study of rural and periurban men found that 69% had paid for sex with cash or goods, and that most of them were married.[71] NHASP's evaluation of all its social marketing campaigns found a consistent pattern in all studies conducted since the start of the Project in 2000: "clearly and consistently, PNG males outrank females for admitted promiscuity by a factor of over 2 to 1".[72] At the same time, women, including married women, are having more sexual partners, yet husbands who leave their wives in the village assume they (the wives) are not at risk of HIV/AIDS. For both men and women, there is a tendency to use condoms more with casual sexual partners than with the primary partner.

Economic conditions: Even in rural areas these days, everyone needs money, and it usually seen as a man's responsibility to provide for the cash needs of the family. The main sources of employment for men are urban-based industries and services, and resource extraction operations (mining, logging and fisheries) and plantation production (of oil palm, copra and coffee), so many men need to migrate for work. Accommodation for families is often not available, so men are therefore separated from their wives for long periods. They look to women and girls in the vicinity to provide them with sexual services, whether paid or coerced. Rates of alcohol abuse and STIs are high.

Other occupations that involve men being away from home, such as truck and PMV driving, and fisheries, also lead to risky sexual behaviours with multiples partners, including sex workers. The police and security company staff also are known to profit from their position to obtain sex. Studies done in 1998 of men accessing commercial

[68] As above.
[69] Cited in Jenkins C. 2005, C*ontrol of HIV/AIDS in Papua New Guinea: A situation assessment and proposed strategy.* The World Bank, AusAID and the ADB, p7.
[70] Pantumari J. and Baume P. 2002. *A Perception of Factors Associated with HIV/AIDS Infection Among Soldiers in Port Moresby, PNG.* Thesis submitted for MPH at the School of Medical and Social Science, UPNG.
[71] Jenkins C. 2005, p 6.
[72] Marketsearch 2005, *National HIV/AIDS Social Marketing Campaign Phase 4 Evaluation, Quantitative Research Report.* March 2005, p 44.

and casual sex in the previous week showed the main occupations to be sailors (54%), security guards (52%), policemen (49%), dockworkers (30%) and truckers (15%).[73]

The deterioration of PNG's economy since the early nineties has reduced the number of jobs available, causing many young men to become involved in criminal activities, exacerbating their sense of frustration and alienation, and further motivating them to other anti-social and risky behaviours. Criminal gangs frequently commit rape while engaged in crimes, and often require participation in rape as a criterion of gang membership. Social mapping reports and several other studies have revealed disturbing levels of sexual exploitation of boys and young men, due to poverty.[74]

Another economic factor putting males at risk of HIV infection is male ownership of land. When patriclans sign land-use agreements with private or public sector organisations for development activities (e.g. logging, mining, fishing, processing plants, the construction of roads, airstrips and other infrastructure), the cash payments are made to the male landholders. This money is quickly spent on drinking binges, purchase of vehicles, and trips to town that often involve risky sexual practices, increasing the risk of STI and HIV transmission to wives on the men's return home. Other income-generating activities, such as the sale of cash crops, are also in male control, and much of the cash produced is used by men to buy sex, often with very young girls

Male to male sex, and homophobia: Male to male sex is common in PNG, but it is illegal, and therefore largely hidden. Homophobia is rife, and young men and boys who appear effeminate can suffer violence, discrimination, and even punitive rape.[75] Sexual activity between males was condoned or even expected in some traditional cultures, but this never prevented or interfered with marriage, and homosexuality was not a recognised sexual identity. Today, too, most men who have sex with men do not claim a homosexual identity.

A recent study found that 58% of men who have sex with men were bisexual, 13% heterosexual, and only 29% self-identified as homosexual.[76] In other words, 72% of men who have sex with men also have sex with women. Most of these had also had anal or vaginal sex with multiple female partners in the previous month, including some who had had sex with their wives. Anal sex is a particularly high risk practice for HIV transmission, yet condom use remains low among men who have sex with men, whether with male or female partners.[77]

Young men may have sex with each other when no females are available, for no payment. The above study found that 32% of study participants had sex for money, and a behavioural study at the STI Clinic at PMGH in 2004 found that 7% of male attendance reported having sold sex.[78] All-male settings such as prisons and military

[73] Jenkins C. 2005, p 6.
[74] NHASP 2005, Milestone 83; Bradley C. 2001, *Family and Sexual Violence in PNG: an Integrated Long Term Strategy.* INA Discussion Paper No. 84; UNICEf and HELP Resources, 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG.* Draft January 05; UNICEF 2005, *Families and "Children Affected by HIV/AIDS and other Vulnerable Children in PNG: A National Situation Analysis.* Draft, March.
[75] Christopher Hershey, MSM program manager, Poro Sapot and SCiPNG, personal communication.
[76] IMR, FHI and SCiPNG 2005, *Quantitative Study Results Among MSM in Port Moresby.* Slide presentation.
[77] As above.
[78] Toole M. 2005.

barracks are acknowledged to have high rates of sex between men, both voluntary and coerced. NHASP's HRSS includes a focus on these institutions.

Sexual abuse of boys: Several recent reports have found evidence that the sexual abuse of boys occurs all over the country, though much less frequently than that of girls. [79] Young boys experience sexual coercion in the church, in schools, in the streets, and in their own homes. It is possible that younger boys are being used for sex for the same reason that younger girls are – in the hope of avoiding HIV/AIDS. Not enough is known about this disturbing phenomenon, and research is urgently needed.

[79] Bradley C. 2001, *Family and Sexual Violence in PNG: an Integrated Long Term Strategy.* INA Discussion Paper No. 84.; UNICEF and HELP Resources 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Sexual Exploitation of Children in PNG.* Draft January 05; UNICEF 2005, *Families and Children Affected by HIV/AIDS and other Vulnerable Children in PNG: A National Situation Analysis.* Draft, March.

2. REVIEW OF PROJECT APPROACHES TO DEVELOPING GENDER EQUITY IN ITS ACTIVITIES

2.1 NHASP's Gender Planning Framework

Gender is an AusAID cross-cutting issue, and gender considerations have been integrated into the Project's operations since its beginning. In late 2002, gender was given increased focus by the development of a Gender Planning Framework. A Gender Advisor was recruited to suggest strategies to support the equitable and active participation of men and women in Project management, planning and implementation, through:

- incorporating a gender perspective into Project activities;
- promoting women's effective participation and leadership in decision-making at relevant levels of Project implementation;
- improving women's access to, and participation in, HIV/AIDS education and training activities;
- minimising the risk of gender discrimination across the Project's seven components; and
- monitoring the NHASP gender planning framework in line with overall Project monitoring and evaluation.

The Framework identified five overall 'targets' for the Project's gender approach (Milestone 36:12). These are:

1. a gender sensitive working environment in-country which ensures that attitudes towards female staff are supportive and equal;
2. Project advisers and partners have the necessary training to enable them to incorporate gender into the planning and implementation of their programmes;
3. Project planning and programmes related to sexual behaviour address social norms, sexual beliefs, gender violence, and gender power disparities in relation to HIV transmission and vulnerability to HIV/AIDS;
4. participation of women and women's organizations in all levels of Project planning and implementation;
5. project workshops, training programs and meetings are planned and structured to facilitate active participation of women and men.

Gender strategies and activities to achieve the above targets were developed under each of the Project's seven components, and a monitoring and evaluation matrix was developed, enabling progress to be reported on as part of the Project's annual monitoring and evaluation exercise (see Annex 3). The Project's components are:

Component 1: Education, Advocacy and Behaviour Change;

Component 2: Counselling, Community Care and Support;

Component 3: Policy, Legal and Ethical Issues;

Component 4: Monitoring, Surveillance and Evaluation;

Component 5: Clinical Services and Laboratory Strengthening;

Component 6: Management and Resource Support to National Response and Programme Partners;

Component 7: Cross-Component Support and Effective Project Management.

Strategies and activities used by the Project to address the five targets will be described, and an assessment made of their impacts, strengths and weaknesses. Lessons learned and constraints will be discussed, and recommendations for consideration by AusAID and for the remaining life of NHASP will be given in the final two sections.

2.2 Target 1: Gender-sensitive work environment in country, which ensures that attitudes toward female staff are supportive and equal.

The Project has used the following approaches towards achieving this Target (numbers in brackets refer to the Components directly concerned):

- recommendation to NACS for the inclusion of equal opportunities provisions, sexual harassment procedures and a Code of Ethics in NAC's Corporate Plan;
- the establishment of workplace policies for PACs which promote an equitable and safe workplace environment, for both staff and volunteers (C6);
- provision of voluntary after-hours basic training on HIV/AIDS, including discussion of gender discrimination, gender stereotyping and human rights, for NACS and NHASP Moresby-based staff (C2, C6);
- collaboration with NACS and the ILO to produce a gender sensitive toolkit on HIV in the workplace (C1, C7);
- required attendance at basic HIV/AIDS training for all PACS staff, volunteers and committee members, including discussion of gender discrimination, gender stereotyping and human rights (C2, C6);
- criteria for recruitment and advertising which, while based on merit, support improved gender balance, particularly in senior positions (C6);
- providing extra security for female staff and volunteers, where necessary, to ensure they are not disadvantaged relative to men in carrying out their jobs (C1, C2, C6).

***Basis of assessment*:**

Assessment of this Target is based on qualitative data obtained during interviews with senior management and administrative staff of NHASP, NACS, three PACs and the four PLCs, and on review of relevant documents.[80]

Assessment:

In NHASP, there is a predominance of women in both senior and administrative positions, but the men interviewed did not feel that women's interests were disproportionately favoured (although it was suggested that women's tendency to emotionalise issues could be inhibiting).

[80] NACS Corporate Plan was still under discussion at the time of the consultancy, and despite several requests, a copy was not made available for review.

In NACS, the opposite situation prevails, with a preponderance of men in both senior and administrative positions. Women here did feel that their lack of numbers (and relative youth) meant that their contribution to decision making was limited. It is hoped that when NACS new structure is implemented in the coming year, there will be sufficient women in senior positions to provide a more gender equitable environment and a critical mass for more active female participation.

No formal complaints have been recorded of harassment of females in NHASP or NACS workplaces. For PACs, the PAC Manual sets out standards of behaviour for a safe and equitable working environment for staff and volunteers, but there are at present no official procedures for the management of complaints. At national level, these matters are expected to be included in the Corporate Plan, which is not yet in place.

At provincial level, there were anecdotal reports of situations where males appeared to be uncomfortable working with women in positions of authority. This is to be expected in cultures where the traditional expectation is that men are in charge. The Project's strong support of women's leadership is valuable in promoting new norms. On the positive side, it was also reported that men trained by the Project often became role models for more gender-equitable working relationships.

Although still in draft form, the workplace manual developed with NACS and the ILO,[81] is being used by employers in different sectors, and with workplace committees established as part of NHASP's High Risk Settings Strategy (HRSS). Information is provided on the ways in which men and women are affected differently by HIV/AIDS and employers are encouraged to identify gender discrimination and create more equal gender relations in the workplace.

It is expected that an evaluation of the impact of this programme, including gender aspects, will be conducted by the ILO at a later date. The impacts of NHASP's activities on gender awareness, training, recruitment criteria and security provisions will be dealt with under Targets 2 and 5.

2.3 Target 2: Project advisers and partners have the necessary training to enable them to incorporate gender into the planning and implementation of their programmes.

The Project has used the following approaches to achieving this Target (numbers in brackets refer to the Components directly concerned):

- compulsory "Introduction to HIV/AIDS" training, including issues of gender and gender violence, for all PAC staff and committee members (C2, C6);
- 2-day training on Gender and HIV/AIDS by UNDP/UNIFEM for some NHASP and NACS advisers in July 2003 (C2, C6);
- inclusion of a short gender session in a 5-day national level training for NHASP and NACS advisers in June 2004 (C7);
- inclusion of gender issues in training on STI/HIV prevention for health workers (C5);

[81] NACS and ILO 2004, *Developing a policy on HIV/AIDS for your workplace: A toolkit for employers and workers in PNG.* March.

- inclusion of discussion of gender issues in workshops conducted with FBOs by the STA for FBOs;
- creation of a Gender Planning Framework, including a "Checklist for Building Gender Equity into Project Design and Implementation" (C7);
- inclusion of a "Checklist for Building Good Gender Practice in the PAC Planning Cycle" in the PAC Administration Manual" (C6).

Basis for assessment:

Assessment of this Target is based on a review of training and procedural manuals produced by the Project[82]; focus group discussion with 20 (9 males, 11 females) accredited NHASP trainers from all four regions of PNG; focus group discussion with 24 persons (16 males and 8 females) who had received the "Introduction to HIV/AIDS" training; gender focus sessions conducted with 69 participants (43 males and 26 females) at the New Guinea Islands and Southern Region PAC Training Workshops; data collected from these PAC training participants on all gender-related trainings they had attended through NHASP or other agencies; a review of the gender content of provincial/district strategic plans, HRS Site Committee operational plans and other documents to guide implementation; and personal interviews with NHASP and NACS staff on their gender skills background and trainings attended.

Gender content of "Introduction to HIV/AIDS" training:

The "Introduction to HIV/AIDS" course, taught by C2 trainers, is the Project's main method of increasing awareness and knowledge about HIV/AIDS. It was developed early in the life of the Project to provide a basic orientation to HIV/AIDS for anyone involved in the prevention of or response to HIV/AIDS. It is a requirement for all Advisors, operational staff and volunteers of NHASP and NACS, and a pre-requisite for all other training courses. It is one of the strengths of the Project that it was decided to include a session on gender and human rights as one of the six topics covered in this five-day course.

The Gender and Human Rights session covers the difference between sex and gender; gender assumptions and stereotypes; gender bias and inequality; types of gender violence; male and female differences in vulnerability to HIV/AIDS; and human rights, stigma and discrimination as they relate to HIV/AIDS.

One full day is scheduled to cover these topics, though in the focus group discussion, trainers said that this is the most challenging part of the whole course to teach, particularly with community based groups. Less experienced trainers said that discussions could become uncomfortable, so they sometimes cut the session short by leaving out the participatory activities and presenting the information verbally.

The trainers themselves clearly understood the importance of gender inequalities for the spread of HIV/AIDS, and were unanimous about the need to include this session, and even expand it. All felt that the session got participants thinking about things differently, and in some cases could achieve personal behaviour change. A sample of comments is given in the box below.

[82] *Introduction to HIV/AIDS; Introduction to HIV/AIDS Counselling and Voluntary Testing; Home Based Care for HIV/AIDS; Strategic Planning for HIV and STI; Training Manual on Behaviour Change Communication,* for HRSS*; PAC Administration Manual*

There was general agreement amongst the trainers that having to teach about gender had caused them to look at their own lives: "People expect us to be good personal role models. They challenge us about our behaviour." Some even suggested that living as good role models achieves more than group training, because Papua New Guineans are more used to learning from observing rather than from talking. In this respect, males can be more influential than females, because "men are the head of the family and whatever decision they make affects the family". Most trainers asked for more ToT on gender issues, to help them improve the impact of their sessions.

Comments from trainers on the gender impact of "Introduction to HIV/AIDS":

"Some participants come to understand the inequality between men and women. Some men express their readiness to change and take a new way of life, becoming responsible. Some women wish their husbands could get the information they are receiving".

"Change in behaviour will take a long time. Although a lot of participants understand the topic, they continue practicing gender inequality. A male participant may attend and understand the issue. But at home, he continues marital rape, or may refuse condom use even if they are involved in extra-marital affairs. If the woman disagrees, she is most often shown the door."

"Some men are very strong in their stance and use culture as their defence. Some women too hold to the belief that their husbands have a right to beat them if they do not follow the wish of their husband."

"A lot of the issues are common and regarded as normal. Leaders question us trainers, "Do you want to change the way our society has behaved for a long time?" I say: "Yes why not? We used to all wear grass skirts, but we don't now - traditions are changing."

The focus group discussion of people who had attended the "Introduction to HIV/AIDS" training session in the last year was also positive about the value of the gender and human rights components in helping them to understand how gender inequalities contribute to the spread of HIV and STIs. However, when they try to pass on this message in their own work, especially in rural areas, it is hard, because "by and large, the male population still feel that they own their women". As one man said: "Men are very slow to see that women have rights just like us".

In other NHASP trainings, gender issues have not been a strong element, except in the training on STI/HIV prevention given to health workers under C5, where gender issues are always covered.

The national workshop conducted by the Burnet Institute in June 2004 on "Managing Community-based HIV Programmes in Developing Countries" for 21 participants (8 males and 13 females) for NHASP, NACS, NDoH, NGOs and AusAID staff, included gender as one of 22 topics covered in the five-day course. The FBO workshop similarly raised awareness of the significance of gender issues, but has not yet progressed to assisting participants to develop programmes for addressing these issues. The two-day UNIFEM training offered in July 2003 did provide training in

gender analysis for HIV, but of the small number of NHASP and NACS employees who attended, only three are still in their jobs.

Gender skills for planning and programming:

Valuable as these gender sessions are in raising awareness of gender issues, they do not provide the kind of gender skills training needed to enable participants to incorporate gender into the planning and implementation of their programmes, nor are they designed as such. Nevertheless, they are the only form of gender "training" received by most NHASP and NACS employees and volunteers.

For example, of the 69 participants in the two regional training workshops for PACs, only 10 males and 7 females had received any other "gender training",[83] none of it through the Project. In all but three cases, the training received consisted of awareness raising, not of skills development

Increased awareness of gender issues relating to HIV prevention and response, though extremely valuable in itself, does not necessarily translate into the ability to develop plans and implement programmes that address these issues. This can be seen from the discussions with participants at two regional workshops for PACs, and from an analysis of provincial/district level strategic plans, HRS operational plans, and NAC's National Strategic Plan 2004-2008.

PACS: At the regional training workshops, each of the eleven provincial groups of PAC representatives was asked to discuss the barriers for women and girls in their provinces which prevent them from acting on ABC safer sex messages to protect themselves from HIV/AIDS. After listing the issues on which they based their assessment, they were asked to suggest how these could be addressed through programming.

All provincial groups recognised that women and girls generally do not have the power of independent decision-making needed for them to be able to act on the ABC safer sex messages, and were able to list the main factors limiting female choices (see Section 3.3 for more discussion of these issues). Vulnerability to sexual and physical violence was mentioned by all groups.

Other key factors listed by most groups were women's economic dependence on men, especially where poverty is increasing; their inability to negotiate condom use or discuss their fears about the husband's infidelity or polygamy; expectations of submissive behaviour for women and girls; arranged marriages and betrothals; females' lack of knowledge about safe sex and difficulty of accessing condoms; the sexual double standard which brands women who carry/use condoms as promiscuous; and women's lesser education and knowledge of their rights.

However, when it came to the implications for programming, most groups continued to suggest the standard ABC-based strategies, of providing more awareness, distributing more condoms, preaching fidelity to married couples and abstinence to young people. Separate male and female needs were not recognised, with "people" and "young people" being seen as undifferentiated groups.

[83] Sources cited were Peer Education training, Anglicare, the Family and Sexual Violence Action Committee of the CIMC, paralegal training by ICRAF, UNDP's Leadership Initiative, HELP Resources Gender Training and Sexual Health training, and Bougainville Reconstruction.

Only three groups identified the need for taking action to reduce the violence against females, and only two specified the need for social, economic and legal measures to reduce gender inequalities and empower women and girls to take protective action on their own behalf. Ironically, these two groups were the NCD and Central Province, whose completed provincial/district strategic plans do not embody these suggestions (see below).

Interestingly, none of the 69 participants, nor any other PAC employee or volunteer interviewed by the consultant, was aware of the "Checklist for Building Gender Equity in the PAC Planning Cycle" contained in section H of the PAC Administration Manual. Neither had any Advisor but one seen the Gender Planning Framework, or the "Checklist for Building Gender Equity into Project Design and Implementation" which is attached to it as an annex.

***District level strategic planning**:* The manual used to guide the district level strategic planning process concentrates almost entirely on the basic techniques of planning, with little reference to gender. The Institutional Strengthening Advisor guiding the process raises gender issues for discussion as appropriate, but there is no concrete framework for addressing these conceptually or programmatically. This has resulted in strategic plans which pay some lip service to gender issues, but have little or no follow-through in programmes, activities, or monitoring and evaluation.

District level strategic planning is a lengthy operation, and to date only the five districts of Central Province and NCD have launched their Plans. A review of these Plans reveals that they all show similar weaknesses in terms of gender-aware planning:

- the plans are framed in terms of gender-blind generic groups such as "people", "general population", "sexually active population", "youth", "young people", "leaders", "families", "communities" etc., as if these were internally homogenous;
- there is no targeting of prevention activities to sex-specific groups, except for female and male sex workers in the NCD, through the Poro Sapot Project;
- the involvement of women is called for almost exclusively as agents for promoting general awareness and providing HBC through the activities of their women's groups, particularly church-based groups;
- gender issues identified in the situation analysis as putting women/girls at greater risk of HIV and STI infection (e.g. "women's subordinate role"; violence in families; rape and gang rape of women and girls; extreme poverty driving both married and unmarried women as well as young girls into selling sex; lower nutritional status of poor women; young girls being married to older men, with or without their consent; higher biological vulnerability; "gender imbalances", "low status of women", "unequal social structures at household, village and national levels" that disadvantage women, etc.) receive no further mention in the strategic response;
- "peer education" is cited as the major means of providing safer sex information and the distribution of male (and sometimes female) condoms, but without any indication of the groups to be reached, nor how peer educators will be trained, resourced and co-ordinated;

- M&E frameworks use the same gender-blind terms as used in the activity plans (e.g. recording "# of local leaders trained", "# of trainings conducted and individuals and organizations involved", "# of awareness sessions held and # of people reached", "# of persons trained in HBC", etc), preventing the collection of any sex-specific data that could be used for future plannings.

NACS: A similar pattern of recognising the significance of gender issues but failing to address these adequately in planning and programming is shown by the National Strategic Plan 2004-08 (NSP) developed by NACS. The Plan was developed by working groups involving nearly one third participation by women (34 out of 101 members), with six female members on the 23-person steering committee, and its situational analysis recognises the gender inequalities that fuel the epidemic.[84] However, "gender is neither a focal theme nor explicitly identified as a cross-cutting theme to be addressed through the seven focal areas". [85]

To address this deficiency, UNDP sponsored a gender specialist to conduct a Gender Audit of the NSP.[86] A one-day workshop was held in June 2005 to share the findings and its 57 recommendations with NACS and NHASP.[87] No senior member of NACS attended this meeting, and only three (female) Advisors from NHASP. An AusAID consultant was tasked with merging the Gender Audit with the NSP, but this had not been taken up by NACS at the time of writing this report.

NACS' immediate priority is to move ahead with obtaining endorsement from the NEC for the original NSP document separately from the Gender Audit document, on the grounds that the NSP was thoroughly workshopped and approved in this form by the working groups. It is not clear at the time of writing how or if the Gender Audit document will be used by NACS, or by what means (if any) the NSP will be given a gender focus.

2.4 Target 3: Project planning and programs relating to sexual behaviour address social norms, sexual beliefs, gender violence, and gender power disparities in relation to HIV transmission and vulnerability to HIV/AIDS.

The Project has used the following approaches to achieving this Target (numbers in brackets refer to the Components directly concerned):

- social marketing and IEC development are based on formative research and include separate focus groups of women, men, female and male youth (C1) ;
- evaluations of social marketing and behaviour change campaigns seek responses from women, men, female and male youth (C1);
- specific IEC materials produced for women and men, female and male youth (C1);
- campaign on stigma reduction addressing women's greater vulnerability (C1);
- support to national and provincial campaigns on gender violence (C1);

[84] NAC 2004, *PNG National Strategic Plan on HIV/AIDS 2004-2008,* p 9-10.
[85] UNDP 2005, June *National Strategic Plan on HIV/AIDS of PNG 2004-2008, A Gender Audit Report,* p 7. Port Moresby.
[86] UNDP 2005, *National Strategic Plan of PNG 2004-2008: A Gender Audit Report.* Draft, June.
[87] See Annex 4

- gender sensitisation included in workshop on HIV awareness for the media (C1);
- promotion of female as well as male condoms (C1);
- research conducted on norms and beliefs relating to sexual behaviour and gender, and used to inform strategic planning at district, provincial and national levels (C1, C7);
- funding male advocates for training at the Fiji Women's Crisis Centre (C2);
- development of male and female trainers as role models for healthy gender behaviour (C2, C6);
- coverage of social norms, sexual behaviours, gender violence and gender disparities to some degree in all trainings, as already discussed under Target 2 (C2, C5, C6);
- HBC activities that reduce women's workload with appropriate technologies and encourage male participation in care (C2);
- provision of gender-specific care for STIs (C5);
- targeted peer education interventions with male and female sex workers, and introduction of a major High Risk Settings Strategy to address risk behaviours in other settings (C1);

Basis for assessment:

Assessment of this Target is based on a review of social marketing campaign materials, surveys and reports; focus group discussion with women's leaders in Wewak, Madang and Goroka; focus group discussion with 20 NHASP trainers (9 males, 11 females); discussions with staff at two STI clinics (Madang and Goroka); discussions with NHASP and NACS staff involved in awareness and behaviour change, training (C2 and C6), social mapping, clinical care and training on STIs, and HBC; visits to the Poro Sapot Project in Boroko and Goroka, and to HRS site committee in Madang; site visit to Appropriate Technology Ltd in Goroka; and review of Project M & E reports and other relevant documents and literature.

Gender in social marketing and IEC development:

NHASP has conducted five social marketing campaigns and developed an extensive range of items of health promotion and IEC materials (163 in total). The first two phases focussed on raising public awareness about the seriousness of HIV/AIDS and how it is spread, on partner reduction, and on the vigorous promotion of condom use. Phase 3 concentrated on stigma reduction and refined the approach to partner reduction by highlighting the invisibility of HIV infection and the value of voluntary testing, newly introduced. Condom promotion was extended to include the creation of a commercial PNG brand, the Karamap, intended to appeal to a wider range of male tastes.

Phase 4's campaign continued to build HIV/AIDS awareness and knowledge, with particular emphasis on stigma issues, reducing tendencies to judgemental attitudes, and reinforcing duty of care and compassionate values. Gender violence was highlighted as an issue affecting HIV prevention amongst women and girls, linking in with the theme of that year's World AIDS Day (2004). Phase 5, still being

implemented, focuses on normalising condom use, particularly amongst the under-25s.

Each Phase is based on an evaluation of the previous Phase, involving quantitative research with an equal number of males and females, and consultation with male and female stakeholders. NHASP employs Marketsearch, a large market research company, to conduct and report on the research. Survey reports present information for both sexes combined, with comments on relevant gender differences, as well as including a specific section discussing the results of all survey questions by gender.

Messages and materials are developed using male and female focus groups. Wherever possible, both sexes are represented in the IEC materials produced. A number of separate materials have been produced for men and women, young men and young women. Both male and female role models, such as public figures in the sports and entertainment worlds, have been used to appeal to various segments of the population. However, though the presentation is changed, the same key messages are used for both sexes. This can have some negative implications for women, as will be discussed below.

Of the 16 posters currently being distributed (32 including Tok Pisin versions), 14 carry images of women. Most of these show adult women modestly dressed, but the posters aimed at urban youth show young women dressed and behaving in ways that are quite untypical of the rural majority: wearing tight, body-revealing, fashionable clothes, makeup, modern jewellery and hairstyles; taking assertive or even aggressive poses; and having close body contact with young men in public. These images may be appropriate for the urban young women at whom they are aimed, but in the rest of the country, where they are distributed through NHASP's and NACS' national networks, it has been found that they can reinforce attitudes which blame young women's provocative behaviour for the spread of HIV/AIDS.[88]

The impact of the various campaigns on awareness, knowledge, attitudes and behaviours and intentions has shown some similarities and some differences between the sexes. In the most recent Marketsearch survey, 90% of men and 88% of women saw HIV/AIDS as the country's most important health issue.[89] Men were only marginally more informed about the ways in which HIV/AIDS is spread. However, some females did not know what a condom was, and only 30% of female respondents had ever used one, compared to 60% of males. Only 15% of females reported using a condom at last intercourse, compared to 35% of males. On both these condom questions, female affirmatives had declined since Phase 3.[90]

Men and women differ in the number of sexual partners reported for the previous 3 months, with 29% of men and 36% of women reporting no partners, 40% of men and 48% of women reporting one partner, and 23% of men and 8% of women reporting more than one partner. However, these figures represent very little change overall since the baseline study.[91]

[88] Mcpherson N. 2005, *SikAIDS: Deconstructing the Awareness Campaign in Rural West New Britain, PNG.* Draft paper for a forthcoming ANU publication on HIV/AIDS in PNG.
[89] Marketsearch 2005, *National HIV/AIDS Social Marketing Campaign Phase 4 Evaluation, Quantitative Research Report*. March.
[90] Marketsearch 2005, p 42.
[91] Marketsearch 2005, p 20.

Of the campaign messages, "Protect Yourself from AIDS" had more appeal to men, (being remembered by 35% of men and only 23% of women), as did "always use a condom when having sex" (remembered by 34% of men and 21% of women). Only 5% of people (sex not known) mentioned "respect women's rights" or "stop violence against women" as one of the main messages they remembered from AIDS messages heard or seen recently.

On the positive side, the acceptability of wife-beating by both sexes has reportedly declined as a result of last year's campaign focus on gender based violence for World AIDS Day. The majority (57%) of the urban/peri-urban population surveyed now say it is not acceptable, females expressing stronger disagreement with the practice than males (65% and 48% respectively). In the previous year there was no gender difference in attitudes, which suggests that the "women and violence" message has been empowering for women. However, these figures are actually lower than those reported by the PNG Law Reform Commission in its extensive 1984-5 urban survey of low-income earners, of whom 75% of females and 58% of males stated that wife-beating was not acceptable. The figures for urban elites were 64% (females) and 59% (males). Figures were considerably lower in the national rural survey of 16 provinces – 43% for females and 32% for males - reflecting more traditional attitudes.

NHASP's strategy is based on WHO's recommended ABC approach, which has been credited with reducing the levels of HIV infection in Uganda and other African countries. In recent years this approach has been criticized for its lack of attention to gender power imbalances and the real situations of women's lives. In some ways, the basic ABC approach may have the effect of actually increasing women's risk. While ABC messages about safer sex behaviours are good public health, like many other health messages, they need to be supported with educational, social and economic programmes to enable people, and particularly women and girls, to act on the behaviour changes recommended. See Sections 3.2 and 3.3 for a fuller discussion of these points.

Fidelity messages are a case in point. Promoting fidelity to wives who suspect or know that their husbands are not faithful to them serves only to reinforce existing cultural and religious pressures on wives. The latest Marketsearch report found that four years of campaigns have increased by about 10% the number of women who believe that the best way to protect themselves from HIV is to be faithful (now at 73%).[92]

This reduces rather than increases married women's options for protecting themselves. Only 10% of women expressed an intention to change their sexual behaviour as a result of HIV/AIDS messages, implying either that that they see themselves as having limited choices, or that they already believe they are behaving correctly (i.e. being faithful).[93] These findings clearly indicate the need for strategies that focus more strongly on empowering women to make safer choices.

Condom promotion also requires more recognition of gender roles and inequalities. Recommending women, particularly married women, to use condoms, without providing the negotiation skills and the supportive environment required, is at best pointless, and at worst, damaging. Condom use requires male participation, and the consultations held for this report showed strong agreement that most married women

[92] Marketsearch 2005, p 12.
[93] Marketsearch 2005, p 4.1

are too afraid of being shamed, beaten or abandoned to ask their husband to use a condom. See Sections 3.3 and 4.6 for further discussion of these issues, and Section 4.4 for some implications for the HRSS.

Male attitudes to women's initiation of condom use need to be addressed before women and girls can safely increase their use of male condoms. Female condoms have not been promoted in NHASP's national campaigns so far. They are, however, included in NHASP's national distribution system for generic male condoms, and are demonstrated in Component 2 and 5 trainings.

Another aspect of NHASP's campaigns that leave women out of the picture is the individualised approach. The theme messages "Lukautim Yu Yet" (You Protect Yourself), and "No Condom, No Sex", have meaning only for people who make their own decisions about sexual activity, who are mostly men. Not having sex unless a condom is used is simply out of the question for the majority of women who depend on men for the economic and family survival. Exhorting them to protect themselves without showing them how they can realistically do this exacerbates their existing fears and feelings of helplessness.[94]

Of course, not all messages have to apply to everyone. It is also true that for many women, behaviour change by their male partners is their only chance of protection from HIV. However, the preventive impact of social marketing and health promotion activities can only be strengthened by improved attention to women's realities. The particular needs of women and girls in relation to the ABC approach are relevant also the new HRSS strategy, and will be discussed in more detail in Section 4.4.

Some Marketsearch findings do not match what is known from other sources. Women's survey answers were the same as men's on questions asking about obtaining condoms easily (48% said they could), believing they can do what is necessary to protect themselves from HIV (77%), and agreeing that it is best to use a condom every time if they suspect their partner of infidelity (48% agreed).[95] However, consultations conducted for this report showed strong disagreement with these findings.

This may be because the quantitative research sampling is strongly skewed towards urban populations (75% urban and 25% being peri-urban, defined as 25-40 kms from a town), towards unmarried people (56% male, 49% female, 2005), and towards youth (44.6% are in the 15-24 age-group, 2005). Only 7% of the females and 2% of the males were separated, divorced or widowed.[96]

Since the end of a marriage can severely impact on women's life choices, the findings may indicate that younger, urban women are feeling more able to make their own decisions about protective behaviours. In general, the survey's findings should not be seen as representative of the vast majority of women living in rural areas, whether unmarried married or formerly married. The same applies to rural men.

Role models for gender sensitive behaviour:

Recognising the value of learning from observation rather than only from instruction, NHASP has explicitly encouraged its trainers, both males and females, to become role

[94] Elizabeth Reid, development practitioner and gender and HIV/AIDS consultant, personal communication. See also Section 3.3.
[95] Marketsearch 2005, p 46.
[96] Marketsearch 2005, p 47.

models for gender-sensitive behaviour. Candidates must be respected persons in their community, and a code of conduct requires them to model in their lifestyle what they are teaching. A disciplinary committee may suspend trainers who behave inappropriately, especially in relation to sexual behaviour, but this has not yet been necessary. The trainers themselves recognise the personal influence they have and appear to take it seriously, as was discussed under Target 2.

Male dominance is a major driver of the epidemic, and males model themselves on other males, so the Project has begun to develop "male champions" for gender equality. For the last three years, three male trainers a year have been funded to travel to Fiji to participate in training on gender and gender violence run by the Fiji Women's Crisis Centre.

This course has an excellent reputation, and the men who have been trained there are highly spoken of. They reported making changes in their own lives, such as helping with domestic chores, sharing household income, taking on more child-care, and coercing their wives into sex. As well, they believe that the training and personal changes have increased their self-confidence and motivation to speak out on issues of gender equality. There is a need to establish this kind of training opportunity in PNG so that men can attend in much greater numbers.

Research on norms and beliefs relating to sexual behaviour and gender:

During 2003-3, teams of local interviewers trained by NHASP in social mapping carried out extensive research throughout the country. The purpose was to collect information from communities on their perception of the social, cultural and economic factors influencing the spread of HIV/AIDS in their own area, so that it could be used to inform the planning of locally appropriate responses. Questions were broad, to allow participants to define their own issues, and included coverage of sexual behaviours and beliefs, gender issues affecting HIV/AIDS and poverty, perceived high risk groups/settings/occasions, stigma and discrimination, and existing local prevention or response initiatives.

Mapping was carried out in every district (89 in total) of 19 of 20 PNG's provinces. Central Province had already been covered separately by a similar exercise. Over 2,000 males and females of all age groups were interviewed, with input from 14,000 others in 1,240 rural and urban communities.[97] A strong effort was made to train as many women as possible for the interviewing teams, but because of the many constraints on women's mobility in rural areas, male interviewers outnumbered females by three to one.

Much interviewing took place during fluid community meetings, so no data were collected on the exact levels of male and female input. Nor were findings separately reported by sex. Nevertheless, the social mapping exercise was a remarkable achievement, productive of a wealth of up-to-date information on perceptions, behaviours and conditions relating to HIV/AIDS, including gender factors, in even remote parts of the country. Each PAC has been provided with copies of the reports for the districts in their province, and along with National Census data, these provide the baseline data for strategic planning. However, this increased awareness has not necessarily led to an improved focus on gender issues in programming, as was discussed under Target 2.

[97] NASP 2005, *Milestone 83, Social Mapping of 19 Provinces in PNG, Summary Report.*

A second social mapping exercise, again including questions put to male and female respondents on sexual behaviours, attitudes and gender issues, is just being completed for the HRSS. Interviewing has been conducted around the high risk sites identified in the pilot provinces, which will be described in the subsection below on the HRSS. The reports to be produced will be provided to the HRS Committees, to assist them in their planning.

Information on sexual behaviour and socio-economic factors relating to HIV/AIDS and STI transmission is also collected by the behavioural surveillance programme being conducted for NHASP and NACS by the PNG IMR. Data are analysed by gender, and periodic reports on findings are provided to NHASP and NACS to guide strategic planning.[98]

NHASP has also funded research conducted by FHI, SCiPNG and the PNG IMR with male and female sex workers in Port Moresby and Goroka. Findings are being used by NHASP, NACS and partners to improve interventions with sex workers and in stigma reduction activities.[99] Through Component 4, studies have also been conducted on sexual behaviour of male prisoners at Bomana jail, and of soldiers at Taurama Barracks.[100]

Female condoms:

Between January 2002 and June 2005, the Project has distributed nearly 400,000 female condoms to all provinces, increasing by 10% each year. It is believed that these are mostly further distributed to female sex workers, among whom they are popular because they can be inserted several hours in advance and therefore rely less on male co-operation than the male condom. They are also sought for the same reason by other women, including women who are going into risky situations where they fear rape.

The female condom appears to be well accepted by women in PNG.[101] It is, however, roughly ten times more expensive than the male condom, and the quantities which the Project supplies (free) always run out fast. The current rate of distribution (126,000 in the first 6 months of 2005) would protect only just over 1,000 sexual acts per month per province. There is an urgent need for further information on the distribution and use of female condoms, and for an expansion of the service. The distribution of female and male condoms is discussed in more detail in Section 4.6.

Home-based care and women's workload:

Women's existing heavy domestic workload, and the added burden of caring for the sick, has been addressed by Component 2 as an important gender issue. The training manual and public information materials parallel the materials used by the NDOH

[98] PNG IMR 2004 August, *HIV, AIDS, STDs and Sexual Health in PNG: a multi-method, multi-sited study. Periodic Progress Report from the PNG IMR.*
Lupiwa T. et al, 2005 September, *HIV/STI Mapping in PNG: Update on the nationwide project.* PNG IMR, Goroka.
[99] FHI, PNG IMR, SCiPNG, NHASP, 2005 June, *Formative Assessment of Female Sex Workers and Men who Have Sex With Men in Port Moresby and Goroka, PNG.*
[100] Pantumari J and Bamne P 2002, *A Perception of Factors Associated with HIV/AIDS Infection among Soldiers in Port Moresby, PNG.* Thesis submitted for MPH, School of Medical and Social Science, UPNG.
Pantumari J. n.d. *Behavioural Study among Inmates of Bomana Prison, Port Moresby, PNG.* NACS.
[101] Jenkins C. 1995, *A study of the acceptability of the female condom in urban PNG.*

Community Action and Participation programme and the Village Health Volunteer training programme these were developed by the AusAID-funded Women and Children's Health Project. They emphasise and illustrate the involvement of men in the caring tasks culturally associated with women, as well as the participation of women in non-traditional decision-making roles.

To try to change the stereotype of women as care-givers, men have been encouraged to participate in C2's HBC training. Of the persons trained as HBC trainers, 35% are men, and of persons trained by the trainers, 44% are men, many of whom are health workers (see also Table 1 for Target 4). At the same time, NHASP staff are very aware of the need for careful selection of male trainees, to ensure that the men trained will actively participate in the work of care-giving, rather than just supervising females in carrying out the tasks.

An important and effective innovation is the use of alternative technologies to reduce the workload of caring for the sick. Through Appropriate Technology Ltd, based in Goroka, "Living with Dignity" kits have been produced, which provide a bucket toilet and water-saving devices for personal hygiene, showering and doing laundry. Twenty of these have been distributed to each province for use by persons living with HIV/AIDS and their care-givers.

An evaluation of these found almost 100% satisfaction among users, especially for the bucket toilet.[102] In the later stages of AIDS, uncontrollable diarrhoea is a constant problem, both for the sick person, who is too weak to get to or use a latrine (or the bush), and for the family, who must usually share the same single-room house where the sick person is lying in soiled bedding and clothing. As well, the arduous chore of carrying many buckets of water (usually long distances uphill) for laundry is much reduced by the provision of a portable toilet for the sick person.

The water-saving washbasin and shower, and laundry-system also reduce the burden for care-giver in carrying water. They allow the sick person to keep themselves clean, which is extremely helpful because people known to have AIDS are usually banned from using the community bathing and laundry places. This is an initiative which is of particular value to women in rural areas, who are overwhelmingly the main carers for those sick with AIDS. Since three quarters of HIV infected people live in rural areas, this is programme that will clearly need to be vastly expanded to meet the rising need as the epidemic grows.[103]

Gender-sensitive STI services:

Gender sensitive delivery of services to STI patients has been improved by the Project in three main ways: establishment of gender-specific services and new facilities, support to the Syndromic Management (SM) of STIs, and the training provided in relation to these. In PNG, there are strong cultural taboos against mentioning sexual matters in front of a person of the opposite sex. Treatment for STIs involves not only a discussion of sexual behaviour but also examination of the genitals, which can be a major deterrent to both men and women. A recent NHASP report on STI management found that "patients have been known to hold back important information when they

[102] Williams B. 2005, *AT Project's Personal Hygiene Kit, Evaluation Report to NHASP and NACS.*
[103] Jenkins C. 2005, July, *Control of HIV/AIDS in PNG" A situation assessment and proposed strategy, p* 17.

are attended to by a health worker of the opposite sex, and not freely discuss their condition".[104] Many others simply do not seek service.

Gender-specific service means that clients are interviewed, examined and treated by a health worker of the same sex as themselves, preferably in rooms reserved for only one gender. Many clinics (mostly below provincial level) do not have facilities allowing for the separate treatment of males and females, so a further 38 new ones are being funded by AusAID. New clinics also increase privacy, more important for women than for men, by their location away from highly visible public areas, eg not by the main entrance, outpatients department, or the morgue (where crowds wait for the bodies of relatives to be released). They are also located away from antenatal clinics, to facilitate attendance by men.

Since Tininga (STI) Clinic in Mt Hagen started providing gender-sensitive service, the number of males attending has tripled and the number of females doubled.[105] In all clinics where gender-specific service is provided, the attendance of young males and females has increased. The Project is also funding the provision of a sexual health clinic for male and female health workers at the Poro Sapot headquarters in Boroko (NCD), due to open later this year. This will minimise the discrimination reported by some sex workers attending other clinics, and contribute to improved sexual health of these high risk groups.

Syndromic management of STIs allows a health worker to prescribe a single, multi-drug treatment on the basis of a description of symptoms, without waiting for the results of laboratory tests, which in many parts of PNG are not available or are unreliable. This is of particular benefit to females, since SM can be carried out even in rural aidposts, and eliminates their need for repeated visits, which their workload and limitations on their mobility can make difficult. The impact of the introduction of SM for STIs is that a much lower proportion of clients experiences complications or relapses of infection.[106]

The training of health workers now treats STIs/HIV as a gender issue, rather than an issue with a gender component".[107] All health workers (nurses, CHWs and HEOs) are now given pre-service training in SM for STIs, including the importance of gender-specific service. In-service training is provided for all staff at the new clinics. Training also covers options for the many rural aidposts and health sub-centres where there is only one health worker on how to minimise embarrassment to patients of the opposite sex.

The risk of transmission of HIV is much greater where an STI is present. The huge burden of untreated STIs in PNG (described in Section 1.2) is a major contributing factor to the spread of HIV/AIDS. The Project's use of a gender-sensitive approach to make treatment more accessible and more effective to both sexes is one of its strengths.

[104] NHASP 2005 May, *Mini-Evaluation of the Competency of Health Workers Trained at District Level, to Syndromically Manage Clients who Have Sexually Transmitted Infections.* p 29.
[105] NHASP 2005, *Milestone 93: Annual Monitoring and Evaluation Report for Year 5.* p 73.
[106] As above, p 71.
[107] NHASP 2004, *Annual Plan 2004,* p 20.

Targeted interventions with male and female high risk groups:

The Poro Sapot Project is an intervention with female and male sex workers and their clients in Port Moresby, Lae, Goroka and Kainantu which is run by SCiPNG, with funding from NHASP. Sex workers in PNG are particularly difficult to reach, because sex work and homosexual sex are both illegal activities, and sex workers face extreme harassment by the police.[108] The Project is assisting NACS' legal advisor to develop options for removing these legal barriers,[109] but this is not likely to have quick results, given the extremely conservative and moralistic attitude in the country.

Poro Sapot uses a peer education approach, modelled on the highly successful Transex Project among sex workers, their transport worker clients and security guards.[110] A recent study has found that although both male and female sex workers have high rates of STIs, low knowledge about HIV transmission and inconsistent condom use, there is evidence that peer education is making a positive impact on condom use and treatment-seeking for STIs.[111] A study of HIV rates amongst sex workers by the IMR is planned, for comparison with rates last reported on in 1998 by the Transex Project.

In 2004, NHASP began piloting another method of reaching high risk groups, through the High Risk Setting Strategy. Four groups have been identified: Group 1, settings where people negotiate for sex; Group 2 , highways and ports; Group 3, disciplinary forces (including prisons); Group 4, private industries; and Group 5, youth at risk in NCD. The strategy uses a peer education model for behaviour change communication developed by FHI, and it is intended that activities will be decentralised and directed by local HRS Committees of trained volunteers.

For the remaining life of the Project, NHASP is moving away from large national campaigns for awareness towards more community based dialogue-based approaches for individual behaviour change, including an increased emphasis on district theatre groups. The HRSS will be the major means for implementation of this strategy. The gender implications of the HRSS will therefore be discussed in more depth in Section 4.4.

2.5 Target 4: Participation of women and women's organizations in all levels of Project planning and implementation.

The Project has used the following approaches to achieving this Target (numbers in brackets refer to the Components directly concerned):

actively encouraging gender balance by requiring the participation of women in all types and levels of training conducted, both as trainers and as trainees (C1, C2, C6);

encouraging the (merit-based) recruitment of women at national, provincial and regional levels (C6);

[108] Fletcher K. 2005a, *Decriminalisation of Prostitution in PNG.* Unpublished paper.
[109] Fletcher K 2005b, *Decriminalisation of Sex Work in PNG, Report of the Legal and Policy Advisor to NHASP.*
[110] Jenkins C. 2000, *Female Sex Worker HIV Prevention Projects: Lessons Learned from PNG, India and Bangladesh.*
[111] FHI, PNG IMR, SCiPNG 2005, June, *Formative Assessment of FSW and MSM in Port Moresby andGoroka, PNG.* Slide presentation.

requirement that all PACs have a women's representative, on the Executive as well as the full Committee (C6);

national training workshop for all PAC women's representatives (C1, C2);

planned national workshop on gender and HIV/AIDS advocacy for prominent women role models and opinion leaders (C1);

strengthening of women's organizations at provincial and community level through grant-funded activities(C7);

actively encouraging the greater participation of women in PAC training workshops and District Level Strategic Planning sessions (C6);

actively encouraging gender balance in trainings with PACs, DACs, NGOs, FBOs and CBOs (C2, C6, C7);

Basis for assessment:

Assessment of this target is based on analysis of data on participation by males and females in Project trainings, workshops and committees; review of women's national training workshop materials; focus group discussions with women's leaders in Wewak, Madang and Goroka and with the Gender Branch of the Department for Community Development; review of the grants database and reports; discussions with PAC/HRS representatives in Wewak, Madang and Goroka, with NHASP Advisors and the PLCs; and review of other relevant documents.

Training in counselling, community care and support:

The Component most actively involved in training is C2. The types of training conducted by this Component are: Introduction to HIV/AIDS; Introduction to HIV/AIDS Counselling and Voluntary Counselling and Testing; Home Based Care for HIV/AIDS; Training of Trainers for these, and Training in Rapid Testing for HIV/AIDS. In addition, several regional/provincial workshops have been held with trainees to evaluate the trainings. Table 1 below shows the level of gender balance achieved in these trainings.

Table 1: Male/female participation in C2 trainings, Jan 03 – July 05

	Males		Females		Total
Type of training	#	%	#	%	
Intro to HIV/AIDS	1620	56	1250	44	2870
Intro to HIV/AIDS Counselling	284	50	289	50	573
Intro to HIV/AIDS Counselling and VCT	169	51	160	49	329
HBC	129	44	166	56	295
ToT: HIV/AIDS	26	41	37	59	63
ToT: Counselling	22	41	32	59	54
ToT: HBC	15	35	28	65	43
Rapid Test Training	14	30	33	70	47
Evaluation Workshops	163	52	153	48	316
Total	2442	53	2148	47	4590

Clearly, this Component has done an excellent job in achieving equitable participation of males and females. For trainers, there is a slight predominance of females. This is in no way problematic, since trainers operate in male-female pairs when possible, and the gender balance of trainees is good, creating an environment where both sexes are

able to participate fully in discussions. As discussed under Target 3, the figures for HBC reflect the efforts made to encourage greater participation of males, in order to change the gender stereotype of women as the sole carers for the sick, and to reduce the workload of women.

Recruitment of women at national, provincial and regional levels:

At national level, NHASP has more women than men in Advisor or senior management positions (16:4), whereas NACS has more men than women (8:2). The gender balance of leadership positions at provincial and regional levels is shown in Table 2 below.

Table 2: Males/females in leadership positions at provincial/regional level

Position	Males		Females		Total
	#	%	#	%	
HRC (where filled)	10	71	4	29	14
PCC (where filled)	6	37	10	63	16
HRSC	3	60	2	40	5
PAC Chairperson (where filled)	17	94	1	6	18
Total:	36	68	17	32	53

Men predominate in the higher paid position of HRC, whereas women predominate in the position of PCC, a role that is seen as fitting with women's traditional role as carers. As mentioned under Target 1, job advertisements specifically encourage women to apply. For all provincial positions, applicants are pre-screened by the national level Advisor for Component 6, and a short-list of candidates is forwarded to the PAC, but often very few applications are received from females. Occasionally, if no applications from females were received, the position has been re-advertised. There is no database to illustrate the extent to which recruitment of females has increased during the life of the Project.

PAC leadership is almost entirely male. The Chairperson is an elected position, and leadership is traditionally a male role in PNG, an expectation that is proving hard to shake. No figures for current PAC memberships were available at the time of this research, but it is well known that most members are male. One reason for this is the need for representation on the PAC from key divisions of the Provincial Government, posts which are usually held by men, reflecting women's educational disadvantage.

In an attempt to counteract this, NHASP now insists that each PAC has a Women's Representative, who is usually the President of the Provincial Council of Women, or the Women's Representative to the Provincial Assembly, or both. There is also a requirement for representatives from Youth, FBOs, and other stakeholders such as local NGOs, CBOs and the private sector. Some of these positions are also filled by women.

With this expanded membership, there has often been a problem for PACs to get a quorum for meetings. The system is therefore in the process of being revised to create Executive Committees in each province, reducing the need for meetings of the entire PAC. A Women's Representative will be a core member of each Executive Committee. A sex-disaggregated database on membership will be created once the PACs have been reconstituted.

Sex disaggregated membership lists for the HRS Site Committees in those provinces where the HRSS is operational are in the process of being collected by the Advisor. There is a strong predominance of males in the 11 committees which have so far provided data, with 74% of the listed members being male. Two committees, for Lae Ports and Lutheran shipping, have no female members, leaving the interests of wives, female sex workers and female office staff unrepresented.

Capacity building for provincial women's leaders:

Recognising that women are under-represented in PACs, the Project is trying by other means to strengthen women's leadership role in the PACs, and at provincial and district levels generally. A five day national training workshop was held in August 2004 for all PAC Women's Representatives, covering basic HIV/AIDS and relatedissues of gender and gender violence. The text box below illustrates the kind of benefits in the province that flowed from the national training.

As a result, several participants applied for and received NHASP grant funding for follow-up activities with women's groups in their provinces. Materials and funding were provided to all participants so that women in each province were able to take the lead in activities for World Aids Day in December 2004, for which the theme was Women and Girls and HIV/AIDS, with a particular focus on violence against women.

A second national training workshop for national and provincial women's leaders is planned for later this year. This workshop will attempt to involve a much broader cross-section of women than the previous one, targeting leading women public figures and opinion leaders from outside the usual National/Provincial Council of Women's network.

Impact in Lae of the National Women's Training:
The attendance by the Morobe women's delegate at the National Women's Training led to a range of flow-on activities and effects after her return to Lae:

- a stakeholder meeting, which identified the need for more HIV/AIDS prevention awareness;
- a three day forum with 43 groups on HIV/AIDS prevention and women's rights, funded by NHASP, at which attendees made commitments to raise awareness with other groups in their home environments;
- opening of the forum by Dame Carol Kidu, with extensive national press coverage;
- Radio Morobe's interviewer created a network of women working on HIV/AIDS for continued radio coverage, and set up a condom distribution point in Radio Morobe;
- local NGOs and service providers learnt about each other's services and have started referring cases;
- many participants who were initially anti-condoms changed their minds after the participatory discussions and seeing male and female condoms demonstrated;
- women were motivated to talk to their work colleagues and families about HIV/AIDS and women's rights;
- a march against violence against women and a candle-light vigil for the 16 Days of Activism on Violence Against Women;
- numerous local events raising awareness about violence against women and girls for World AIDS Day, using NHASP materials and funds.

Information from a follow-up evaluation conducted by the PLC for Morobe.

Women's groups are encouraged to apply for grant funding, and in the last eighteen months, six provincial workshops have been held to assist local organizations to develop successful applications.[112] Of the 195 participants, 43% (84) were women representing a range of women's youth, faith-based and community organisations.

The Grants database for the period Jan 2004 to July 2005 lists 15 grants made to women's groups, and of the 165 other activity grants made, most appear to include women/girls amongst the intended beneficiaries. Some women's group activities included outreach to men also. No groups applying for grants identified themselves as men-only groups, though of the small number of youth, theatre and church groups reporting back, several had very few or no female participants.

It is not possible to be more specific, because although the form for reporting on grant activities requires the listing of beneficiaries by sex, these forms are seldom received back by the Project. PLCs have now been tasked with following up on grant reporting.

Skills training for women in planning and implementation:

Under C6 and C7 (HRSS), the Project has provided several kinds of training in relation to project planning and implementation: in project planning, management, monitoring and reporting for PAC members; in strategic planning at district level; in social mapping for provincial and district level strategic planning; in social mapping for HRS sites operational planning; and in Behaviour Change Communication (BCC) for the HRSS. Table 3 below presents the available data on gender balance in participation.

Table 3: Male/female participation in skills training for planning and implementation

Type of training	**Males**		**Females**		Total
	#	**%**	**#**	**%**	
Regional PAC Training Workshops					
New Guinea Islands	19	65	10	35	29
Highlands	23	77	07	23	30
Momase	11	55	09	45	20
Southern Region	24	60	16	40	40
Total:	77	65	42	35	119
District Strategic Planning Workshops					
Madang	30	73	11	27	41
NCD	19	59	13	41	32
Central	37	82	08	18	45
Sandaun	37	86	06	14	43
Morobe	32	71	13	29	45
Total:	86	73	32	27	118
Strategic Planning facilitation	33	60	22	40	55
Social Mapping for District Strategic Planning	164	75	54	25	218
Social Mapping for HRS Sites	25	76	08	24	33
BCC for HRSS	36	69	16	31	52

[112] ESP, Morobe, ENB, WHP, Madang, Sandaun .
Provincial Grants Workshops, internal report by Passingan-Bongare D, NHASP Grants Administrator, 2055.

As Table 3 shows, women are under-represented in training for participation in project planning and implementation, with participation levels ranging from a low of 14% to a high of 45%. To some extent, the reasons for this are beyond the control of the Project: the lack of women in relevant managerial and technical positions due to female disadvantage and stereotyping in education; the tendency of women as well as men to elect men to leadership positions; women's reluctance to risk their safety when moving between isolated communities for social mapping research. More efforts are needed to reduce these disparities. There is also a need for sex disaggregated data bases. At present, there are only separate lists of participants at each event.

2.6 Target 5: Project workshops, training programs and meetings planned and structured to facilitate active participation of women and men.

The Project has used the following approaches to achieving this Target (numbers in brackets refer to the Components directly concerned):

- invitations to organizations participating in workshops and training programmes specifically request the participation of women;
- mixed-sex workshops and trainings take care to facilitate full participation by both sexes, and single-sex options are available if requested (C2, C7);
- women participants are encouraged to bring their husbands if they have security concerns (C1 social mapping, C2, C6);
- secure accommodation is provided at or close to the event location, and per diems cover expenses (C1, C2, C5, C6);
- travel is arranged by the most secure method, with the provision of a police escort in areas of tribal fighting, for both men and women (C1, C2, C5, C6).

Basis for assessment:

Assessment of this target is based on discussions with NHASP Advisors, PLCs, trainers and trainees, and the data presented for Target 4, which illustrate the impact of Target 5's efforts to facilitate the active participation of women and men. However, as already mentioned in relation to male/female attendance at workshops and trainings, lower overall levels of female attendance are more a reflection of long-standing gender disparities in society than of deficiencies in NHASP approaches. As well as sustained efforts to encourage women's participation, there is a need to consolidate the above practices as formal guidelines, so that they can be sustained by NACS and whatever initiatives take over from NHASP in the future.

2.7 Constraints

The Project is faced with many constraints which impinge on its effectiveness in promoting gender equity in and through its activities. Most of these relate to the entrenched culture of female inequality throughout PNG society generally (as described in Section 1), which make it difficult or impossible for women to take up some of the opportunities offered by the Project, and for men to support or even understand what is really required for greater gender equity. Gender roles and norms are fixed early in life, and are hard to influence. The Project's emphasis on gender sensitivity, gender balance, the promotion of male role models and the inclusion of

awareness of gender issues and human rights in training are appropriate strategies, but it is a long uphill struggle.

As the Gender Audit of the NSP reported, "there is only a rudimentary understanding of gender on the part of a majority of stakeholders … and a low level of awareness and sensitivity about gender issues among policy makers, parliamentarians and senior bureaucrats".[113] The fact that gender was not integrated into the NSP from the outset indicates the need for a greater knowledge on the part of NACS, NDOH and other national level stakeholders, while at the provincial and district levels, gender capacity is even lower. There is a need for a more pro-active approach from donors to raise the profile of gender and develop more gender capacity with all partners, particularly the public sector.

The lack of a tradition of female public leadership hinders the Project's efforts to increase participation and prominence of women. The National Council of Women is not an effective partner for a number of reasons (see Section 4.7), and the sole (though very active) female member of parliament cannot single-handedly mobilise the political will and resources needed if rhetoric about gender equality is to be more than lip-service.

The legacy of low female access to education, particularly at higher levels, means that women remain severely under-represented in senior management in the public and private sectors, and therefore in NHASP, NACS and PAC trainings that require certain technical capacities. Removal of barriers to the full participation of females in education and in political decision-making are essential long-term goals for a gender equitable approach to HIV/AIDS. In the short term, the Project's broadening of the decision-making base to include representatives of women's, youth and faith-based organizations, and supporting women's leaders through training and grants are addressing this constraint.

The extremely high levels of physical and sexual violence against PNG women and children remain a major constraint on efforts to reduce the gender inequities driving PNG's HIV/AIDS epidemic. Interventions from all sectors have been minimal, and continue to be hampered by fatalistic attitudes on the part of women as well as men, who see male violence as an inevitable fact of life. The Project has contributed to raising awareness of gender based violence, and now needs to ensure that this awareness is acted on, both within its own activities and in those of its partners (see Section 4.3).

The stigma associated with HIV/AIDS remains high and women and girls are disproportionately blamed for their "promiscuity" and "greed" as carriers of infection, with little recognition of the social and economic factors which make them vulnerable. Many churches promote judgemental attitudes, as well as opposing condom use. This is particularly problematic since half PNG's rural health services are provided by FBOs, as are many VCT centres. Women, youth and sex workers are more likely to fear discrimination in church-run services. The Project's support of health worker training through NDOH, social marketing campaigns, and strengthened dialogue with FBOs, address these constraints.

[113] UNDP 2005 June, *National Strategic Plan on HIV/AIDS of PNG 2004 – 2008: A Gender Audit Report.* Port Moresby. p 26.

The poor state of PNG's health services has negative implications for the delivery of effective gender-sensitive services for STIs and for the clinical care of AIDS patients. Supply of STI drugs is inconsistent even in provincial centres, and in rural areas there is minimal capacity for providing gender-specific, private and confidential care for STIs. The Project is assisting with facilities and training, but supply problems with drugs, and with the rubber gloves, bleach and other items needed to protect health workers and Village Health Volunteers from HIV infection, remain a challenge.

In most of PNG's traditional cultures, public discussion of sex is taboo. This limits open dialogue, allows the proliferation of rumours and misinformation, and hinders people's perception of their own risk. HIV/AIDS tends to be seen as a problem of urban or mobile high risk groups, and people who stay at home in the village, especially married women, tend to see themselves as safe. Yet male habits of multiple sex partners, travel, drinking, sexual violence, and low condom use bring HIV/AIDS into every district of the country. Women and girls, too, are becoming increasingly mobile. Many of NHASP's activities address these issues, but PNG's mountainous terrain, dispersed islands, limited infrastructure and the high cost of transport make the task of bringing appropriate information and interventions to rural areas a daunting one.

Finally, rapidly growing poverty is pushing more and more women and children – already the most vulnerable sections of the population – into risky sexual behaviours for their own survival, or through an inability to protect themselves from coercion. Young, unemployed men, too, are becoming alienated and turning to crime, violence, and other anti-social and harmful behaviours. Project strategies take these realities into account, while GoPNG and donor partners develop broader policies and programmes to reduce poverty.

2.8 The Project's Gender Strengths

1. The project has taken a mainstreaming approach to gender (as a cross-cutting issue), and male and female gender issues identified in the Gender Planning Framework are addressed in annual planning and integrated into the activities of each Component.
2. Project monitoring and evaluation includes performance indicators for gender, which are reported on separately.
3. NHASP has a gender-sensitive working environment, and there is a high level of interest in gender overall on the part of all female and male Advisors and senior staff, though some are more active than others. Several had a previous background in gender. The in-country Team Leader has a good level of competence in gender issues, and has ensured that gender is well covered in annual planning.
4. At provincial level, gender issues are discussed, and the Project's emphasis on "gender balance" in trainings, planning and implementation is well understood. An appropriate gender balance is usually achieved in C2's trainings around the country.
5. The Project's support of the involvement of civil society stakeholders (women's groups, youth groups and FBOs) in workshops, consultations and PACs has increased the level of women's participation in planning and implementation, and training of provincial women's leaders has strengthened women's awareness work in their communities.

6. The basic training in HIV/AIDS required for everyone involved in the HIV/AIDS response through NHASP contains a strong focus on gender. There is good coverage of gender issues as they affect both males and females, and of human rights. The standard of trainers is high, and most have received accreditation according to PNG and Australian national standards. The trainers themselves and the training programme are periodically evaluated, which has allowed NHASP to maintain quality control of the information being delivered. This is particularly important for the sessions on gender and human rights, which challenge the cultural norms of trainers as well as trainees.
7. Project trainings are delivered to mixed-sex groups. Normally, sexual matters are never publicly discussed in mixed-sex groups in PNG, so in this the Project is making an important stand for normalising the open discussion of sexuality. Open public dialogue on sexuality has been found to be one of the key factors in Uganda's success in reducing the spread of HIV/AIDs, perhaps more important than condom promotion.[114] See the text box below for trainers' assessment of the value of mixed-sex training.

Some trainers' views on mixed-sex trainings:

"Mixed groups are better, because it helps men to see that women really are equal, not down below. It shows that this information is for everyone, not just for men." (Female).

"We need to change the thinking of men and women, so mixed groups is the way to do it. Finally we are starting to see that men and women are speaking openly about these things". (Male)

"Men and women have different words for talking about sex, so this way you learn about it, and then when you hear it in the streets, you know what they mean". (Female)

"It depends on the facilitator. If he or she creates a good feeling, a mixed group is good. If not, and if the men are older, the men will always dominate". (Male)

"Mixed groups are good for in-service trainings, but for doing awareness in villages, it should be separate. Women don't like to hear men talk about sexual things and women's bodies, and the same for men. Young people seem to be OK about it though." (Female)

8. Trainers for C2 are explicitly encouraged to act as role models for gender equality.
9. The Project has recognised the significance for HIV transmission of PNG's huge burden of untreated STIs, and has used gender-sensitive strategies for addressing this through the Syndromic Management approach to STIs, the promotion of gender-specific STI services, inclusion of gender issues in C5 trainings with health workers, and improved facilities and training.

[114] The Panos Institute 2003, *Missing the Message? Twenty years of learning from HIV/AIDS.* London: the Panos Institute, p 12. www.panos.org.uk

10. The involvement of men in HBC is aimed at changing gender stereotypes and reducing women's workload. Alternative technologies have been introduced which also reduce women's workload, as well as some of the discrimination against people sick with AIDS, especially women.

11. The Project's national education and awareness campaigns have been based on research with adults and youth of both sexes. Materials and methods have been tailored to these groups separately for some aspects of the campaigns, with separate analysis of impacts. Coverage has been thorough for the higher risk population segments: young, unmarried, urban and peri-urban males and females.

2.9 The Project's Gender Weaknesses

1. Neither NHASP nor NACS has a system of gender focal points. The Gender Planning A gender mainstreaming approach has limited effectiveness unless it is supported by specialist gender expertise and a formal gender management system and structure involving senior executives. (See Section 3.1 for further discussion). The Project has received only one input from a gender specialist, halfway through its planned lifetime. Framework has not been used by anyone other than NHASP's Team Leader.

2. Gender reporting is done by the M & E team, and Advisors and staff are not required to report regularly on gender.

3. NHASP's major partner, NACS, continues to have a male-dominated working environment, and its NSP mentions gender issues but barely addresses them. The planned system of counterparting and mentoring, which might have raised the level of gender sensitivity in NACS, has not functioned as intended.

4. There are no adequate sex-disaggregated databases on Project trainings, workshops, meetings, and committee memberships which would allow levels of female/male participation to be tracked through time and by activity. Only C2 keeps a database on training participation where the sex is recorded, but not in a way that allows tallies to be kept. For M & E reporting, male and female figures are added up manually from figures presented in the quarterly reports. All other Components keep only lists of participants at activities, often without the sex identified.

5. Provincial and district level strategic plans, and operational plans for HRS Site Committees identify gender issues in their situational analysis but do not target these in programming. The gender coverage of the "Introduction to HIV/AIDS", which is the only gender training provided by the Project, is sufficient to raise awareness of the issues, but does not develop skills for addressing them.

6. Levels of female participation in strategic planning remain low at around 25%, with a range of 14% to 41%. This is largely due to female educational disadvantage and the lack of qualified female candidates, but it is also partially a reflection of some inconsistency of commitment to gender equity within the Project.

7. C2's training has emphasised quality over quantity. This in itself is not a weakness, but it has led to a situation where demand for training is already outstripping supply, and this will increase as the epidemic speeds up.

8. The ABC approach used by the Project needs to be more strongly supported by education and programmes addressing women's realities in PNG and enabling them to act on safer sex messages. This is further discussed in Sections 3.2 and 3.3.

9. Competence for addressing gender based violence as it affects women diagnosed with HIV through antenatal care, STI clinics, VCT centres and when seeking medical treatment is extremely low. C1's efforts to raise awareness of the issue through a national campaign have not been accompanied by a focus on solutions. C2's coverage of GBV in training has also raised awareness but without resulting in provincial programme development so far.

10. Rural people have not yet been sufficiently targeted by the national social marketing campaigns. IEC materials showing modern, sophisticated urban men and women are sent to rural areas, which can reinforce villagers' perception of HIV/AIDS as an urban problem, associated with young women's "lax morals".

11. Peer education strategies to reach adult and youth males and females have been used minimally, and have not been co-ordinated with those of other partners.

12. Surveillance and research do not yet allow for proper tracking of factors affecting gendered aspects of the epidemic, such as age at first intercourse, age at first marriage, sexual coercion and trans-generational sex. Sero-prevalence surveillance data are presented in ways which do not accurately portray male/female differences (see Section 4.9).

13. Policies for the distribution of male and female condoms do not yet adequately address the difficulties of women and girls in accessing and initiating the use of condoms.

2.10 Lessons Learned

A focus on gender, with appropriate frameworks, reporting systems and specialist technical support, needs to be fully integrated from the outset. When brought in half-way through, there are difficulties with adding gender sensitivity to already developed materials, activities and methods of recording data.

On its own, gender awareness/sensitivity training does not produce a cadre of individuals able to plan and implement gender responsive programmes. Gender is an area of specialist expertise, with its own techniques and knowledge base, and must be resourced as such. This is particularly true in PNG, where prevailing values support male dominance, extreme gender power disparities are institutionalised and gender roles are seen as determined by God and/or culture. Sustained technical support on gender is essential to counteract the tendency to revert to the status quo.

When technical support in gender is not available, programmes developed tend to address women's 'practical gender needs' at the expense of their 'strategic interests' (which require the transformation of unequal gender relations). For example, condom policies aim to protect women by distributing male condoms to men, recognising that men control sexual relations, rather than also empowering women to readily access male and female condoms and safely negotiate their use, which would advance their strategic interest for greater equality and power of self-protection.

Adding more women does not necessarily increase gender sensitivity. Women have been socialised to accept gender inequality, as men have. Unsensitized women can be just as critical as men of efforts to change gender relations.

Raising awareness does not necessarily generate attitude change. Even **after** gender awareness training, some women still blame female promiscuity for the epidemic, hold wives responsible when their husbands don't stay faithful to them, believe that husbands should discipline their wives by beating them, blame rape on girls' choice of clothing, call for the abolition of human rights and the imprisonment of HIV positive sex workers, and so on.[115] Awareness efforts need to be sustained.

By integrating gender issues and human rights into basic HIV/AIDS training, more people have been reached than would have been if these matters had been dealt with in a separate training. A separate additional module is appropriate for people whose work requires them to have a deeper understanding of gender issues.

Discussion of intimate matters of sexual behaviour, including non-penetrative sexual behaviours, and the demonstration of male and female condoms, can indeed be carried out in PNG by trained people, despite the strong cultural barriers to public discussion of sexuality.

Materials made available (such as the Gender Planning Framework and the 'Gender Checklist' in the PAC Manual) are not used unless the intended users are trained and required to do so.

Failures in NDOH's distribution system for drugs and infection control supplies continue to undermine the effectiveness of NHASP's gender-sensitive response to STIs and of the health worker training to reduce the stigma of HIV/AIDS.

[115] All these comments were made to the writer during the preparation of this report by women who had received NHASP gender training in the 'Introduction to HIV/AIDS' or the national training for women's leaders.

2.11 Gender Impact Rating

Based on the review of the Project's achievements for each of the Targets described in Section 2, the differential impacts of the activities were found to be satisfactory, according to AusGuidelines 13.[116]

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
	X			

[116] Ref: http://www.ausasid.gov.au/ausguide/5stages/stage5/1.cfm

3. KEY ISSUES FOR AUSAID

3.1 International Guidance on Gender and HIV/AIDS

All major international authorities now recognise that a gendered approach to HIV/AIDS is critical.[117] Research has established that "gender integration maximizes the effectiveness of programmes by reaching more people and reducing constraints to accessing and using information, technologies and services for all", and that it "yields more sustainable results by lowering the incidence of infection and mitigating the negative consequences of AIDS".[118] Equity considerations based on human rights, too, support the case for an approach to HIV/AIDS that addresses the needs of females as well as of males.

Devastating though the pandemic is, it does offer a strategic opportunity for accelerating the transformation of gender inequalities. The threat to a country from an escalating epidemic if women are not equally protected from infection is easily enough understood, at all levels of society, to be an effective motivator for change. By the same token, experience in Africa has shown that if gender is not given a central place in HIV/AIDS responses, the effect of the epidemic is to worse the situation of women and girls relative to men and boys.[119]

There is also international agreement that an effective gendered approach requires dual complementary strategies.[120] The mainstreaming of gender considerations into all levels of planning, implementation and reporting must be teamed with targeted programmes for women and girls (or men and boys, in aspects where they are disadvantaged).

Mainstreaming for gender and HIV/AIDS itself involves two strands: mainstreaming gender into specific HIV/AIDS programming, and mainstreaming "gender and HIV/AIDS" across sectors as part of a multisectoral approach. Mainstreaming has become a key method for enhancing women's equality since the 1995 Beijing Platform for Action, but it has not been consistently successful in ensuring that women's concerns are adequately addressed. It is the subject of continuing controversy, with many practitioners and analysts concluding that gender can be "mainstreamed into oblivion".[121]

Problems associated with mainstreaming are:

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[117] E.g. WHO 2003, *Integrating Gender into HIV/AIDS Programmes: A Review Paper.*
The World Bank 2004, *Integrating Gender into HIV/AIDS Programmes: An Operational Guide.*
IGWG and USAID 2004, *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organisations.*
UNAIDS 2002, *Gender and AIDS Module: Integrating HIV/AIDS Components into Existing Gender-Based Health Programmes.*
The Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach.*
UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS: Confronting the Crisis.*
[118] WHO 2003, p 41-2.
[119] UN 2004, *Facing the Future Together: Report of the UN Secretary General's Taskforce on Women and Girls and HIV/AIDS in Southern Africa.*
[120] Commonwealth Secretariat 2002, p 14.
[121] Womenwatch 2000, *UN Good Practices in Gender Mainstreaming*.
[121] E.g. Association for Women in Development, Nov 2004. *Gender Mainstreaming : Can it Work for Women's Rights?* Discussion Paper No. 3, p 7.
WIDE 2001, *Gender Mainstreaming for Invisibility or Women's Empowerment?* Report by the Gender Mainstreaming Committee of the European Union and Member States. www.eurosur.org/wide

- a tendency to treat mainstreaming as an end in itself, a once-off "tick the box" activity, without sustained technical support, training refreshers/upgrades, mentoring or resources;
- failure to recognise and address deep-rooted gender prejudices, staying at the level of lip-service;
- confusion of gender sensitisation with gender skills training, which leaves senior policy makers and middle level professionals without the necessary skills in gender analysis, gender planning, and the interpretation of gender sensitive indicators in monitoring and evaluation;
- localisation of gender skills at one level, or with one person;
- unavailability of, or lack of access to, relevant gender disaggregated data;
- lack of gender management structures and systems for regular co-ordination and reporting;
- low level of political will; and
- lack of a "critical mass" of women in decision-making bodies, or an active civil society.[122]

All of these factors apply to NHASP's situation, and quite possibly to AusAID's other sectoral programmes which are based on the gender mainstreaming – "gender as a cross-cutting issue" – model. IN fact, a recent review of AusAID multisectoral HIV initiatives in PNG found that although "gender was identified as a critical factor related to HIV/AIDS incidence and to effective responses", it "received little attention in most projects".[123] It recommended that a focus on gender in analysis, selection and design of response, and in monitoring and evaluation, be promoted. Suggestions for addressing the above weaknesses will be discussed in Section 3.2.

The lack of gender awareness and analysis skills is particularly problematic in the light of WHO's global review of approaches which integrate gender into HIV/AIDS programming.[124] This study found that many programmes actually worsen women's situation through lack of gender analysis, and that this was the most pervasive shortfall of all the programmes examined. Programmes were classified along a continuum, ranging from those which exacerbate gender inequalities, through programmes which accommodate gender differences, to those which aim to transform gender relations, with the most advanced set going beyond health interventions to reduce gender inequalities by empowering women and girls.

The review found that programmes can do harm to women by reinforcing negative gender stereotypes, providing the same interventions to men and women when their needs are different, or by providing different interventions when their needs were the same. For example, providing information about perinatal transmission of HIV only to mothers does harm by masking male co-responsibility for infection, undermining efforts to encourage shared parenting, denying men the information they need for co-operating in healthy outcomes, and putting women in a position where they risk their own safety if they tell their partner or the baby's safety if they decide not to tell. The

[122] Based on Commonwealth Secretariat 1999, *Gender Management System Handbook;* and 2002, previously cited; WHO 2003 previously cited; and personal experience.
[123] Patrick I. 2005, *Review of AusAID Multisectoral HIV Initiatives in PNG,* p 31.
[124] WHO 2003.

review concluded that the first principle of programming for gender and HIV/AIDS must be to "do no harm". Effective training in gender sensitisation and analysis skills is a fundamental prerequisite for this principle to be put into practice.

At the other end of the scale are programmes which take an empowerment approach to gender and HIV/AIDS. Here again there is agreement among international authorities that "the key to overcoming the HIV/AIDS epidemic is through transforming relations between women and men, so that women will be able to take greater control of their lives".[125] The mother-document for the global fight against HIV/AID, the UN Special Session Declaration of Commitment (June 2001), contains several key articles which describe the ambitious and extensive nature of the changes called for.

Article 59: By 2005, develop and implement national strategies that promote the advancement of women and women's full enjoyment of all human rights; promote shared responsibility of men and women to enjoy safe sex; and empower women to have control over and decide freely and responsibly on matters related to their sexuality to increase their ability to protect themselves from HIV infection.

Article 60: By 2005, implement measures to increase capacities of women and adolescent girls to protect themselves from the risk of HIV infection, principally through the provision of health care and health services, including for sexual and reproductive health, and through prevention education that promotes gender equality within a culturally and gender sensitive framework.

Article 61: By 2005, ensure development and accelerated implementation of national strategies for women's empowerment, the promotion and protection of women's full enjoyment of all human rights and reduction of their vulnerability to HIV/AIDS through the elimination of all forms of discrimination, as well as all forms of violence against women and girls, including harmful traditional and customary practices, abuse, rape and other forms of sexual violence, battering, and trafficking in women and girls.

Women's empowerment has also been recognised as essential for other key aspects of development. The 1994 Cairo Conference found that "population and development programmes are most effective when steps have simultaneously been taken to improve the status of women".[126] The third of the UN's Millenium Development Goals is to "promote gender equality and empower women". As well as being an instrument for improved development outcomes, women's empowerment is also a matter of human rights. UNFPA, UNAIDS and UNIFEM have jointly stated that "Human rights, gender equality, and women's empowerment provide the foundation for combating HIV/AIDS".[127]

For these reasons, international authorities agree that HIV/AIDS is more than just a health problem. Creating an effective gendered approach to HIV/AIDS extends beyond health sector interventions to transform the fundamental dynamics of gender roles and relationships, and the political, economic and social structures in which

[125] Kofi Annan, Secretary General of the UN, cited in UNAIDS, UNFPA and UNIFEM 2003, *Women: Meeting the Challenges of HIV/AIDS.*
[126] *UN International Conference on Population and Development, Programme of Action,* Para 4.1 excerpt.
[127] UNFPA, UNAIDS, UNIFEM 2003.

gender inequalities are institutionalised. The implications of the international experience for AusAID's role in PNG will be considered in the next sections.

3.2 Strengthening Capacity in Gender

Overall, the level of gender expertise in PNG is low. The gender capacity of the Women's Division of the Department of Community Development and of the National Council of Women, never adequate in the first place, has declined over the last few years.[128] PNG has not yet produced its first report on CEDAW implementation, due eight years ago. UNIFEM conducted a gender mainstreaming exercise with PNG's Department of Finance and Planning in the nineties, yet the lasting benefits of this are hard to detect.[129]

As pointed out in section 3.1, it is essential to provide decision-makers and implementers with appropriate skills in gender-responsive programming so that programmes can meet WHO's first principle of doing no harm. The experience of NHASP has shown that training in gender awareness alone generally does not result in programming that is gender-sensitive or empowering for women, and some examples were identified in Section 2 where some harm may have been done.[130] The Project had one input from a short term Gender Advisor halfway through its originally anticipated life, and no other follow-up or support. The resulting absence of a gender focus in strategic planning by both NHASP and NACS at national, provincial and district levels was described in Section 2.3.

The use of gender advisors in AusAID's other sectoral programmes has also not been strong.[131] Both the Education sector and the Rural Development and Infrastructure sector have had recent inputs from HIV advisers with a gender focus, but little has been done specifically on gender.

The exception to this has perhaps been the Law and Justice Sector Programme, which has benefited from regular and consistent support from a short term Gender Advisor since the outset. This has resulted in a strong gender focus in strategic planning as well as programming, the production of several useful background papers (which could be usefully shared)[132], the introduction of some basic skills training in gender analysis, and the recent creation of a position for a long-term, local Gender Advisor, who will continue to be supported by regular inputs from the short term Advisor.

As mentioned in Section 3.1, the recent AusAID report on multisectoral initiatives showed that mainstreaming gender as a cross-cutting issue was not successful in increasing a focus on, or competence in, gender issues relating to HIV/

[128] Schoeffel P. 2004, *Pacific Platform for Action on Women: Evaluation of Achievements.* Report of the Pacific Women's Bureau, Secretariat for the Pacific Commission, Noumea.
[129] For example, the NSP of NACS, and the provincial/district strategic planning manual of NHASP/NACS were largely the work of a NHASP Advisor who had been trained in gender during UNIFEM's mainstreaming exercise.
[130] Some examples are: promoting married women's reliance on fidelity as a means of protecting themselves from HIV infection; distributing to rural areas posters promoting condom use portraying images of "promiscuously" dressed girls as seen through rural eyes; HIV and STI testing protocols which provide no support for partner notification for women diagnosed with HIV or an STI, nor referrals or guidance on dealing with a violent response; raising married women's awareness of their risks of HIV without providing realistic options for self-protection, thereby increasing their fear and sense of powerlessness.
[131] Personal communication, Angela Clare, Second Secretary Health and HIV, AusAID, Waigaini.
[132] LJSP Project Design Document and annexes on gender, and poverty.

AIDS. It would therefore be strategic for AusAID to take a broader look at how gender can be strengthened in all its funded activities in PNG. Possible avenues include:

- promoting political leadership on gender and HIV/AIDS and on gender overall, and supporting PNG in meeting its international obligations on gender under UNGASS, CEDAW and the Millennium Development Goals;[133]
- commissioning a Gender Skills Mapping Exercise, to explore what skills exist in-country, establish a register of people with proven experience in providing training in various levels of gender analysis, and identify gaps to be filled from outside the country;
- liaising with the new Office of Development for Women to be set up in early 2006 under the Minster for Community Development (for which a Priority Focus Area is to "gender sensitize the highest political, policy and decision-making mechanisms of Government in PNG") to identify ways of urgently developing in-country capacity in gender-responsive planning and programming;[134]
- requiring that technical support in gender (preferably within a human rights framework) to be provided from the outset of all sectoral programmes, either by permanently attached advisors, or by regular short-term inputs, with consistent courterparting. (It is possible that gender could otherwise fall through the cracks of AusAID's new system for capacity development where it only responds to partner-initiated requests for gender expertise, since gender has never been a priority area for GOPNG, despite the rhetoric);
- collaborating with other bi-lateral and multi-lateral donors to convene a Gender Technical Advisory Group, for regular information- and resource- sharing, and co-ordinated development of approaches ;
- setting up a gender resource-sharing system and/or support group for short- and long- term gender advisors, to provide key gender documents and institutional orientation to new-comers, allow for sharing of lessons learned, and the development of a more consistent approach between sectors.

Recommendations for consideration:

5. Promote the mainstreaming of an explicitly gendered approach to HIV/AIDS in all sectoral programmes, and support this with technical and financial resources, systematic management and reporting at all levels, and the development of in-country expertise in gender analysis and gender-responsive planning and programming.
6. Raise the profile of gender as a development issue in general and as an HIV/AIDS issue in particular, and increase technical and financial resources for implementing programmes for women's empowerment across all sectors.

[133] Political leadership has been identified as "the most crucial element" in the success of Uganda, Senegal, Thailand and Brazil in containing their epidemics. The Panos Institute 2003, *Missing the Message? 20 years of learning from HIV/AIDS,* p 7. London: The Panos Institute.
[134] Ministry for Community Development 2005, Office of Development for Women Charter, p 9.

3.3 Gender-sensitising the ABC Approach

NHASP and NACS have followed WHO's lead in basing prevention strategies on the ABC concept: Abstain from sex (or delay the start of sexual activity); Be faithful to one uninfected partner who is also faithful to you; use Condoms. When seen in the context of highly unequal gender relations, these options do not make sense for many women and girls. Women and girls have up to four times the risk of contracting HIV from sexual intercourse, yet they must depend for their protection on the choices made by men.

In PNG (and especially where brideprice is paid), women and girls are not generally able to make their own decisions about whether to abstain from, or delay, sex. Or at least, they are not able to act on their decisions without male co-operation. The sexual double standard means that many more men than women have multiple sex partners and same-sex partners. Promoting fidelity to a married woman whose husband has other wives, girlfriends or male sex partners increases, not diminishes, her risk of HIV or STI infection, unless she is also empowered to use condoms in her sexual relations with him.

Yet NHASP national social marketing campaigns have increased the proportion of women who intend to rely on fidelity as their best means of protection from HIV, without markedly increasing married women's access to condoms, nor their skills for negotiating condom use, and without a corresponding increase in men's stated intention to be faithful.[135] Also, the distribution in rural areas of the 'Show You Care' and 'She's Perfect' posters, which show young women in westernised dress and touching young men in public (highly untraditional behaviour) only reinforces the view of rural people that girls get HIV because of their modern, "promiscuous" behaviour.[136] In their view, the solution lies in tighter control of young girls' behaviour and earlier marriage to stop them "playing around", not better availability of condoms.

It is of course true that condoms are not necessarily the answer for most married women in any case, because they want children and the survival of their marriages depends on this. Also, for married women as well as for unmarried women and girls, much of their sexual activity is forced upon them, without the chance to negotiate condom use.

Even in consensual sex, there are other barriers to condom use for women, whether single or married. Condoms have been promoted in PNG primarily for use in non-marital (i.e. "promiscuous") sex as part of an individualised approach: "Lukautim Yu Yet!" An alternative approach, used in some other countries, would be to promote condom use as part of a caring relationship (see Section 4.6). This would create a more enabling environment for women to negotiate condom use within a regular relationship, where their risk is greatest.

Practitioners and researchers in other countries have found that marriage is actually a risk factor for HIV infection in women. Studies in Kenya and Zambia have shown that younger married women have higher rates of infection than unmarried, sexually

[135] Marketsearch 2005, p 41.
[136] Mcpherson N. 2005, *SikAIDS: Deconstructing the Awareness Campaign in Rural West New Britain, PNG,* pp 13-20. Draft chapter for forthcoming ANU publication on HIV/AIDS in PNG.

active girls in the same age group.[137] Estimates suggest that 60-80% of women currently infected with HIV in sub-Saharan Africa have had only one sexual partner.[138] In PNG, IMR behavioural surveillance has found that "housewives" comprise one of the largest risk categories for infection.[139] The NSRRT research found that among urban and peri-urban men, 71% reported extramarital sex, with 19% having had at least 5 extramarital partners, whereas only 21% of the women interviewed reported having had extramarital partners.[140]

The Ugandan experience has been held up as an example of the success of the standard ABC strategies in reducing infection rates for HIV. But more recent analyses suggest that other factors were equally, if not more important: a commitment to gender-sensitive HIV prevention, gender transformative innovations, efforts to empower women and eliminate gender based violence, and the creation of an open dialogue on sexuality.[141] As one women's NGO worker in South Africa put it: "When I started this work I was very happy to go around preaching 'ABC'… I was like a faithful apostle and we would tell the women. But just alone by my reading and my consultations with my friends who are more gender specialists than I am, I realised we were actually talking about something that wasn't possible for women".[142]

It must also be recognised that raising awareness among women, especially married women, about their risks of contracting HIV/AIDS can increase their fear and sense of powerlessness unless some more meaningful solutions are provided.[143] In South Africa, organisations working with women in agreed that regardless of the degree of awareness of HIV infection risks, women still experienced overwhelming feelings of helplessness in negotiating protection.[144] In PNG, one PCC put it this way: "Women are scared, scared, scared!!!! It's a kind of silent tsunami, if that's the right word. A great big disaster, but women don't want to face it. Because what can they do about it? Just hope and pray, really."[145]

To explore what is possible for women, the debate needs to move away from a narrow focus on techniques towards a more comprehensive focus on conditions. Women's best chance of protection lies in conditions that would allow them to:

- exercise "sexual agency" by making their own decisions about when, how and with whom they have sex;
- have genuine options about when to marry, or whether to marry at all;

[137] Cited in UNAIDS, UNFPA and UNIFEM 2004, *Key Facts and Figures on HIV/AIDS,* www.genderaids.org
[138] Cited in UNDP 1999, *Gender and the HIV Epidemic: Men in the HIV Epidemic.* UNIFEM's Gender and HIV/AIDS Electronic Library, www.genderaids.org
[139] Hammar, Lawrence. 2004a. *Surveillance and sampling in suspicious settings: lessons learned from PNG. Unpublished paper presented at the conference on HIV/AIDS in PNG,* ANU.
Hammar, Lawrence. 2004b. *The double whammy: STDs and sexually transmitted dis-ease in Papua New Guinea.* Unpublished paper.
[140] Cited in Jenkins C. 2005, p7.
[141] WHO 2003, p 45; The Panos Institute 2001, p 18.
[142] CADRE 2003, *Gender-Based Violence and HIV/AIDS in South Africa – Organisational Responses.* UNIFEM Gender and HIV/AIDS Electronic Library, www.genderaids.org
[143] Elizabeth Reid, development practitioner, gender and HIV/AIDS consultant, personal communication.
[144] CADRE 2003, section 4.
[145] Ruth Paliau, PCC for Eastern Highlands, personal communication.

- be protected from sexual violence in their homes, communities, workplaces and schools, and from physical abuse and intimidation from the men in their lives;
- leave abusive or unfaithful relationships without forfeiting their children, or being thrown into poverty;
- have free access to information, testing and treatment for STIs and HIV without fear of stigma or punishment;
- have access to post-exposure prophylaxis (PEP) for HIV and STIs after sexual assault.

Recommendation for consideration:

3. Develop further strategies (social, educational, economic and political) to enable women and girls to take greater control of their own sexuality and act on safer sex messages (ABC).

3.4 Gender Based Violence

It is well established that GBV "constitutes an urgent public health problem worldwide, particularly in the context of the HIV/AIDS epidemic".[146] United Nations organizations agree that "gender-based violence is now one of the leading factors in the increased rates of HIV infection among women".[147] Research has shown that gender violence and sexual health are linked in a number of ways and that the experience of violence is "a strong predictor of HIV".[148] For example, a Tanzanian study of women clients of a VCT service, found that ten times more HIV-positive women reported violence than similarly aged HIV-negative women.[149] A South Africa study of antenatal mothers found that women who experience partner violence were nearly 1.5 times more likely to be HIV infected than those who had not.[150]

Physical and sexual violence are also linked with higher rates of STIs. In an Indian study of men with STIs, rates of sexual abuse of their wives were 2.5 times higher and rates of extramarital sex were six times higher than amongst men without an STI.[151] Childhood sexual abuse is known to be linked with a range of high risk sexual practices (e.g. early sex, more partners, abuse of drugs and alcohol, low condom use) in adolescence and adulthood, and to higher rates of teen pregnancy.[152] For many girls, onset of sexual activity is not a matter of choice, but of coercion.[153]

Sexual violence, both within marriage and outside it, directly increases the risk of HIV transmission through the likelihood of some degree of genital trauma in the woman, and her inability to negotiate condom use or other safer sexual practices. With children or teenagers, physical damage is even more likely. Evidence from

[146] Global Coalition on Women and AIDS and WHO 2004, *Violence Against Women and HIV/AIDS Information Sheet.*
[147] UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS*: *Confronting the Crisis*, p 3.
[148] WHO 2003, *Integrating Gender into HIV/AIDS Programmes, A Review Paper,* p 16. Other studies supporting this are cited in Jenkins C. 2005, p 8.
[149] WHO 2003, p 16. .
[150] WHO 2003a, *Gender Dimensions of HIV Status and Disclosure to Sexual Partners: Rates, Barriers and Outcomes, A Review Paper.*
[151] Reported in Global Coalition on Women and AIDS and WHO 2004, *Violence Against Women and HIV/AIDS Information Sheet.*
[152] Heise et al 1999, *Population Report: Ending Violence Against Women,* p 15.
[153] As above, p 10-11.

around the world, including PNG, indicates that between one third and two-thirds of sexual assault victims are 15 years and younger.[154]

Women's fear of physical violence from their partners may also prevent them from negotiating safer sex, as well as from seeking counselling and testing, STI treatment, reporting rape and receiving post-exposure prophylaxis against STIs and HIV (where available), disclosing their HIV status, and preventing transmission to their babies by taking nevirapine and formula-feeding their babies.[155] Research on the link between marital violence and HIV infection in the PNG context is currently being funded by NHASP, with the report expected in mid-2006 (see also Sections 4.3 and 4.5).

The forms and very high rates of gender violence in PNG were described in Section 1.5. PNG exhibits all of the socio-cultural and economic indicators which research elsewhere has identified as key enabling conditions for violence against women and children.[156] These include:

- rigid gender roles;
- cultural tolerance of the physical punishment of women and children;
- masculinity linked to dominance, aggression and control over women;
- acceptance of violence as a means of settling disputes;
- male control of wealth and decision-making within the family;
- women's economic dependence and limited access to education, employment;
- women's isolation and lack of community supports;
- children and women living/working in unsafe situations due to poverty;
- lack of law enforcement for crimes of violence against women and children;
- lack of services, social activism and political advocacy on gender violence. [157]

Some of the above are consequences as well as causal factors of violence, e.g. women are educationally disadvantaged partly because of the risks of sexual attack and sexual harassment to which attendance at school can expose girls. Gender violence is thus a self-reinforcing system, which can only be dismantled by sustained, society-wide action at all levels.

In PNG, since the pioneering work of the PNG Law Reform Commission on domestic violence first drew attention to GBV as a serious social problem rather than a personal or family matter twenty years ago, there has been little progress overall. The most promising has been the establishment of the Family and Sexual Violence Action Committee (FSVAC) under the Consultative Implementation and Monitoring Council, which since 2001 has been working (with a staff of two) on its own multisectoral long-term strategy in six focal areas: institutional framework; legal reforms; services for victims; perpetrators; community prevention and response, and data collection.[158] There have been some worthwhile achievements, but more inputs

[154] Heise et al 1995, *Sexual Coercion and Reproductive Health*, *A Focus on Research,* p 13.
[155] CADRE 2003, *Gender-Based Violence and HIV-AIDS in South Africa – Organisational Responses.*
[156] Heise L. et al 1999, *Population Reports: Ending Violence Against Women,* p 8.
[157] Heise L. et al 1999, *Population Reports: Ending Violence Against Women,* p 8.
[158] Bradley C. 2001. *Family and Sexual Violence in PNG: An Integrated Long-term Strategy.* INA.

of funds, personnel and technical support in gender and gender based violence are needed for greater effectiveness.

Dame Kidu's efforts have succeeded in passing a law on marital rape and in improving the laws on child abuse and other sexual offences, but there is still insufficient awareness of these new provisions. An NGO (ICRAF) has a programme for awareness and training paralegals, but is vastly under-resourced. The LJSP has introduced some training on gender violence with Community Police and with village court magistrates, but the benefits of this are not yet clear. Several hospitals have set up a special facility for victims of domestic violence and sexual assault, but none are yet operating reliably. The lack of trained volunteer counsellors to run them is a major barrier. The NDOH is piloting a protocol on domestic violence initiated by the Women and Children's Health Project, but still has no official policy on domestic violence, nor on rape and sexual assault,[159] nor even on HIV and AIDS[160]. PEP for HIV is not available to rape victims except through the Catholic health services.

Three donor initiatives are in the pipeline. UNAIDS has recruited a consultant to develop and pilot a training package on advocacy on GBV before the end of the year,[161] and UNDP has announced that PNG is to be one of two countries selected for a study on GBV and HIV/AIDS. Also, UNDP's upcoming programme on Conflict Prevention and Recovery is expected to include an analysis of gender based violence as a risk factor for the escalation of broader conflicts.[162]

In terms of programming solutions, international authorities such as the Commonwealth Secretariat, the Global Coalition on Women and AIDS, WHO and the World Bank recommend a multisectoral approach to eliminating gender based violence.[163] A recent World Bank review of gender based violence in middle and low-income countries has identified promising approaches for preventing and responding to gender based violence, with typical pitfalls and problematic approaches, for the justice, health and education sectors, and cross-sectoral programmes.[164] These are listed in Annex 5.

Some of the approaches listed are already being used in PNG, but only to a limited extent. The lack of expertise in gender based violence in the country, and the dearth of technical support in gender based violence provided by donors, has limited the scope and effectiveness of existing programmes. Too much has been left in the hands of CSOs who are poorly resourced, both financially and technically, and may indavertently use methods or perpetuate attitudes that are counter-productive.[165] Even

[159] A draft medico-legal protocol commissioned by the FSVAC and funded by UNFPA has been two years in the making, but is not yet suitable for piloting.
[160] A draft policy is expected to be finalised by the end of 2005.
[161] Dr Nii-k Plange, UNAIDS Country Coordinator, personal communication.
[162] Jacqui Badcock, UNDP Resident Representative, personal communication.
[163] The Commonwealth Secretariat 2002, *Promoting an Integrated Approach to Combat Gender-based Violence: A Training Manual.*
The Global Coalition on Women and AIDS and WHO 2003, *Violence Against Women and HIV/AIDS: Critical Intersections.* Information Bulletin Series, No 1.
[164] Bott S., Morrison A. and Ellsberg M., 2005. *Preventing and responding to gender-based violence in middle and low-income countries: a global review and analysis.* World Bank Policy Research Working Paper 3618, June.
[165] For example, the recent draft FSVAC publication *Family and Sexual Violence: A Manual for Facilitators and Trainers in PNG*, contains material on rape that clearly implies blame of the victim (p 129, 137), and a discussion exercise that requires women to reveal to the whole group their experience of domestic violence (p140), amongst other examples of gender insensitivity.

at Project/Programme Advisor level, gender based violence has seldom been recognised as specialist area.

On the part of many Papua New Guineans, motivation to address gender violence appears low, despite the rhetoric, because of entrenched attitudes about male power and privilege, women's inability to change their lives to reduce their exposure to violence at home and in the community, and a general hopelessness about the massive scale of the problem. As pointed out in Section 2.3 (Target 2), violence against women and young girls was identified as a key issue affecting the spread of HIV/AIDS in NHASP's district/provincial strategic planning sessions and PAC trainings, but not followed through in programming.

Some authorities call for regular large-scale population-based surveys of forms of gender violence as a way of tracking changes and of creating a high public profile for the issue. For PNG this is unnecessary, for several reasons: sufficient research already exists for political advocacy purposes, the problems are so widespread as to be part of everyone's almost daily experience directly or indirectly, and research in rural areas where most of the population resides is very difficult and expensive.

Adding questions on sensitive issues such as violence into other surveys, such as Demographic and Health Surveys, tends to produce unreliable results.[166] In any case, increases in rates do not necessarily mean the problem is worsening, but could indicate success in raising awareness and service provision, and vice versa. The proposed surveillance system of the HRSS could produce some useful gender-violence indicators, if the additions suggested in Section 4.9 are adopted.

Ways in which AusAID could give a much higher priority and focus to gender based violence include:

- identify any in-country expertise in gender based violence as part of the suggested Gender Skills Mapping Expertise, in Section 3.2;
- examine existing sectoral support programmes for their implications related to gender violence (e.g. micro-finance schemes for women that increase women's risk of violence as men try to confiscate the loan or earnings; enrolling girls in schools where physical conditions – e.g. location of latrines – and organisational deficiencies expose them to sexual abuse from male staff and pupils);
- make specialist technical support in gender based violence available to existing sectoral programmes, and to relevant stakeholders, e.g. the new Office of the Development of Women in the Ministry for Social Development, the FSVAC, the Melanesian Council of Churches and the Evangelical Alliance, etc;
- require that GBV as well as HIV/AIDS be addressed in all funded gender sensitisation or gender skills trainings and materials development;
- convene a workshop of public sector and civil society stakeholders to assess needs and identify strategies on gender violence, including child sexual abuse and exploitation, with a particular emphasis on building an effective response from the justice sector at all levels, and on providing services for victims

[166] Ellsberg. M, Heise L and Shrader E. 1999, *Researching Violence Against Women, A Practical Guide for Researchers and Advocates.* Centre for Health and Gender Equity and WHO.

(appropriate health care, counselling, safe accommodation, legal aid, income-earning opportunities etc.);

- support the LJSP with legal expertise to change discriminatory legislation against female sex workers and men who have sex with men (using groundwork funded by NHASP but not progressed by NACS);
- promote programmes by men for men which encourage them to take responsibility for changing male behaviours in ways which support women's empowerment and gender equality. This will be discussed in more detail in Section 3.5 on involving men.

Recommendations for consideration:

4. Take a long-term multisectoral approach to gender-based violence as an integral and explicit part of gender and HIV/AIDS mainstreaming, with a major and sustained investment in developing in-country technical expertise in gender based violence, particularly in the justice, health, education, civil society (including FBOs) economic and governance sectoral programmes.
5. Move beyond awareness-raising of gender based violence to creating an enabling environment for behaviour change by both women and men (women to protect themselves from violence, men to learn new skills and values).

3.5 Involving Men

The ABC messages used so widely around the world have targeted mainly men for several reasons. Control of sexual relations is generally in the hands of men, men have more sexual partners than women, and men are more prone to other behaviours that increase the risk of HIV transmission, such as alcohol and drug abuse; sexual aggression; peer group pressures; migration for work; mobile occupations; and residence in all-male situations such as prisons, army barracks, mining and logging camps and road construction sites. Equally important are cultural constructs that associate "being a man" with the domination of women and expectations about male privilege in all aspects of life, not just sexually.[167] These factors combined endanger men, and through them the women and children with whom they have sex, and whose lives they control.

When HIV/AIDS is seen through a gender lens, it becomes clear that prevention of HIV/AIDS requires not only changing ideas about how men and women should relate to each other, but changing also the institutions, laws, and economic and social structures in which these ideas are embedded. Since men hold the power, men must become actively involved as leaders in the change process. There needs to be another paradigm for behaviour change communication by and for men, which moves beyond private, individual change to communication for social change.[168]

In this, the concept of "masculinity" is helpful, because it focuses attention not just on problematic male sexual behaviours, but on the totality of how a society defines what

[167] See Greig et al. 2000, *Men, Masculinities and Development: Broadening our work towards gender equality.* UNDP Gender in Development Monograph Series #10.

[168] See The Panos Institute 2002, *Communication for Development Roundtable Report: Focus on HIV/AIDS Communication and Evaluation.*
IGWG and USAID 2004, *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAID and Partner Organisations.*

it means to be male. Over the last decade, it has been recognised that for operational purposes it is more useful to think of "masculinities", because what it means to be a man is not the same in all segments of a society, and can change over time, sometimes quite quickly.[169] This is particularly relevant in PNG, with its extraordinary cultural diversity, and rapid rate of social change.

Cross-culturally, constructs of masculinity show many common features that relate to HIV/AIDS vulnerability. Men are expected to be strong, in control, unafraid, sexually active, tolerant of pain, self-reliant, and knowledgeable. Dominance over women, particularly wives, is another commonality. In PNG, even in matrilineal societies, men often beat their wives for no other reason than to "remind them who's boss", and at the same time to demonstrate to other men that they are in charge at home.[170] Brideprice is seen as legitimising this.

Violence and aggression are also seen as masculine traits, in PNG as elsewhere. In the Highlands this is particularly so, linked no doubt with a history of tribal fighting, in which a community's survival might depend on the strength of its warriors. Early anthropological accounts described the "sexual antagonism" that existed between men and women, connected with the custom of "marrying the enemy", where peace was made by an exchange of women, and with beliefs about menstruation and women's polluting properties.[171] A resurgence of tribal warfare, along with poverty, gangs, gun culture, and glorification of violence in the mass media are exacerbating violence in the region, and the spread of HIV. In the statistics on HIV according to province of origin, all Highlands provinces show markedly higher rates than the rest of the country.[172]

Some observers have suggested that PNG's high rates of violence against women are linked to a "crisis in masculinity".[173] Masculine identity is fragile, because manhood must be achieved, and validated by peers, whereas womanhood is simply attained at the onset of menstruation, or on marriage, or birth of the first child. Male initiation rites, involving tests of endurance and acquisition of esoteric knowledge, are far more common the world over than female initiation rites. In PNG, boys above the age of six or seven traditionally spent all their time with older males, who trained them in how to be men. This training ranged from informal role-modelling, through direct instruction and demonstration, to formal initiation rites, and in many parts of PNG was centred around the "haus man" (men's house) of the community. Women were strictly excluded, and could be killed for observing male-only activities, even if by accident.

Males shared a sense of solidarity with other males, and of supremacy over females, developed through rituals and cult activities, warrior training and tribal warfare, arduous trading journeys, long hunting trips, and so on. In modern times, these activities have fallen away, at the same time as men's prestige as custodians of customary land and leaders of exchange ceremonies has declined in today's

[169] WHO 2003, *Integrating Gender into HIV/AIDS Programmes, A Review Paper,* p 11.
[170] Bradley C. 1985, *Attitudes and Practices Relating to Marital Violence Amongst the Tolai of East New Britain, PNG*. In PNG Law Reform Commission Monograph No. 3, p 50-51.
[171] Three seminal works were Meggitt M. 1964, *Male-Female Relationships in the Highlands of Australian New Guinea"*. In American Anthropologist 66: 204-224; Langness L. 1967, *Sexual Antagonism in the New Guinea Highlands: A Bena Bena Example.* In Oceania 37: 161-177, and Strathern M. 1972, *Women In Between.* London: Seminar Press.
[172] NACS and NDOH 2004 *HIV/AIDS Quarterly Report, December 2004.*
[173] Jenkins C. 1998:51; Bradley C. 1994 and 2001; Dickerson-Putnam 1998; Zimmer-Tamakoshi 1997.

consumer-oriented cash economy. Violence against women can be seen as an attempt by men to recreate a sense of solidarity and control, which partially compensate for their powerlessness in other areas of life. Gang rape, in particular, has a strong element of male bonding, and functions "to demonstrate domination and control of female sexuality".[174]

Strategies for involving men in sustained behaviour change must be grounded in an understanding of the complexities of masculine identities, and the institutions which support them. Experience elsewhere, as well as in PNG, has found that gender based violence is an effective entry point for this work, and there is a wealth of material available. The website for INSTRAW (United Nations International Research and Training Institute for the Advancement of Women), for example, lists ten pages of online documents, toolkits and websites dealing specifically with involving men in ending gender based violence.[175] There is also a great deal of material available on men's involvement in reproductive health since the 1994 Cairo Conference, led by UNFPA's Men as Partners initiative.[176]

A review of the literature suggests that key elements affecting success are:

- identifying role models of alternative behaviours;
- addressing systems of abusive beliefs rather than symptomatic behaviours (a lesson learned from behaviour change programmes with convicted perpetrators);[177]
- providing skills training in non-violent alternatives;
- ongoing support groups;
- focussing on boys and young men (especially pre-sexual activity);
- using idealistic as well as utilitarian motivations (e.g. appealing to men's desire for a better world for their children/daughters, not just their wish to avoid prosecution), and reflection on how men also suffer from aggressive masculinity;[178] and
- creating alliances with human rights' and women's organizations.

Latin America, where "machismo" rules, has produced several model programmes of men taking action to end gender based violence and bring about more equal gender relations. "Puntos de Encuentro" (Meeting Points) uses male role models to mentor groups of young men, as well as using entertainment-education, including television, radio, street theatre, murals and music festivals to promote non-violent sexuality.[179] "Men Against Violence" in Nicaragua developed skills training in resolving marital

[174] NSRRT and Jenkins C. 1994:102
[175] http://www.un-instraw.org/en/index.php?option=content&task=blogcategory&id=119&Itemid=183
[176] The UN International Conference on Population and Development, Program of Action, para 4.27 states: "*Special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour…Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women".*
[177] Russell M. 1995, *Comparison of Confronting Abusive Beliefs and Anger Management Treatments for Assaultive Males.* Family Violence Prevention, Department of Health, Canada.
[178] A useful toolkit for engaging men and boys can be found at http://toolkit.endabuse.org/WhyMenAndBoys
[179] The Panos Insititute 2002, *Focus on HIV/AIDS Communication and Evaluation, Nicaragua.*

disputes peacefully, trained 700 trainers in anti-violence methods, and following a disastrous hurricane, linked with 150 organisations for a national campaign with the slogan "Violence against women: a disaster which men CAN avoid".[180]

South Africa too has developed several "best practice" examples of working with men. The "Men as Partners" programme focuses on gender based violence and sexual and reproductive health, parenting, and support and care for people living with HIV/AIDS. Week-long educational workshops are held with men in workplaces, trade unions, prisons, FBOs, communities and sporting arenas, where discussion centres on the consequences of restrictive and unequal gender roles and the challenges of change.[181] The "Stepping Stones" project has been much praised for its success in bringing about community change through involving men and boys, as well as women and girls, in an intensive four month community-based programme questioning traditional sex roles and promoting improved communication between the sexes for reduced HIV transmission.[182] Other international best practice case studies can be found in the Gender and HIV/AIDS Library on the website shared by UNIFEM and UNAIDS at www.genderaids.org

PNG has its own positive examples of male involvement in changing men's violent behaviour. The Law Reform Commission's video "Stap Isi" (Take it Easy)[183] is a docu-drama based on the stories of two men (one rural, one urban) who learned how to stop beating their wives. Hundreds of men volunteered their time to promote the video and distribute the Commission's leaflets on domestic violence and rape, and many letters were received from men who claimed that the video had changed their lives. The Men Against Violence (MAV) in Port Moresby is a small but committed group of men who run workshops with youth, which lead to behaviour change.[184] Another all-male group has conducted workshops on men's sexual and reproductive health, within a framework of gender equality, in the Eastern Highlands and Madang areas.[185]

In building on this groundwork, some pitfalls must be avoided. If FBOs become involved, there is a danger that male dominance will be reinforced through scriptural justification of men's role as head of the family. Secondly, changes in constructions of masculinity must not proceed ahead of matching changes in constructions of femininity. For example, young women often reinforce male violence by showing pride in the bruises and black eyes inflicted by their boyfriends, interpreting them as a

[180] As above.
[181] Verma M. 2003, *How can men work as partners in ending violence against women and in HIV/AIDs related prevention, care and support? An examination of the Men As Partners(MAP) programme in South Africa.*
A description of the programme is available in the "Working with Men" section of UNIFEM's Gender and HIV/AIDS Library on www.genderaids.org , and the training manual is available from EngenderHealth: www.engenderhealth.org
[182] Full description at http://www.igwg.org
[183] Available from the FSVAC, 321-1714/1397, or pngfvac@daltron.com.pg
[184] The Co-ordinator and main trainer is Robert Titi, National Commissioner for Youth in the Department of Community Development, who is dedicated to this work, and intends to make it a full-time activity in his retirement, if funding can be found. Responses to two one-week courses run recently with out-of school youth in Gerehu and funded by the FSVAC, were extremely encouraging. There seems to be a huge unmet demand among young men for this kind of training. Formal evaluation of the longer term effectiveness of this approach would be useful.
[185] Contact person for Eastern Highlands Men's Reproductive Health Project: Max Tinkena, Researcher, Divine Word University and Modilon Hospital, Madang, HIV/AIDS Retrospective and Prospective Study.

sign of caring, showing that the boyfriends are "treating them like a wife" and thinking of paying brideprice. Many wives still accept a husband's right to beat them.

Thirdly, men's initiatives must not deflect funds or attention away from developing women's leadership and services for victims of male violence. Fourthly, programmes must be evaluated, to ensure that strategies do not cause unintended harm (e.g. reinforcing men's control over decision-making, or allowing an emphasis on heterosexual transmission to prevent men who have sex with men from being aware of the risk of homosexual transmission[186]). And finally, programmes must not ignore the male victims of violence, caused by homophobic attitudes and laws. [187]

Options for AusAID action include:

- make male involvement a focal area for the Technical Working Group on Gender;
- liaise with other donors and stakeholders to identify needs, challenges opportunities and priorities for a co-ordinated approach;
- commission a literature review and summary report on male/female sexuality and constructions of masculinity and femininity, to make available to donors and stakeholders;
- further develop and fund the network of male "change agents", which NHASP is recommended to initiate in Section 4.8;
- consider running in PNG the kinds of courses run in Fiji by the Fiji Women's Crisis Centre on gender and gender based violence for the police, the military, correctional services, and men generally. Men funded by NHASP to attend these trainings have found them transformative, and recommend expanding this approach;
- progress the removal of laws against homosexual behaviour through the LJSP, as suggested in the previous section, and ensure that education approaches address safer sex practices for men who have sex with men.

Recommendation for consideration:

6. Involve men in behaviour change strategies that are based on an understanding of cultural concepts of masculinity and the socio-economic structures that maintain them, and aim to change both, in order to create more equitable sexual relations and norms of gender identity for both sexes.

3.6 Multisectoral Strategies for Women's Empowerment

As UNAIDS, UNFPA, UNIFEM, and other leading international authorities have stated, "the ABC approach will present viable options for women and girls only if it is part of a package of interventions that empower them to claim their rights".[188]

Education and economic empowerment have been identified as key components in improving women's and girls' ability to protect themselves from HIV infection. In 17

[186] Information from male prisoners at Bomana suggests that men who have sex with men may perceive HIV as a "women's issue" and do not interpret HIV prevention messages as relating to themselves. Sue Noordvik, Enhanced Co-operation Officer at Bomana prison, personal communication.
[187] UNAIDS 2000, *Men and AIDS – a gendered approach: 2000 World AIDS Campaign.* Geneva, UNAIDS. www.unaids.org
[188] UNAIDS, UNFPA and UNIFEM 2004, *Women and HIV/AIDS: Confronting the Crisis,* p 2.

African countries and four in Latin America, studies showed that better educated girls tended to delay having sex and were more likely to insist that their partner use a condom.[189] A recent analysis suggests that if all children received a complete education, the economic impact of AIDS could be greatly reduced and seven million cases of infection in young people could be prevented worldwide in the next decade.[190]

However, without special measures, more and more girls will be denied an education as the epidemic spreads and they are kept home to help care for the sick, or because there is no money for their school fees. Females will become increasingly disadvantaged educationally and economically. They will also have less access to information about how to prevent the transmission of HIV and STIs. A 2004 study of secondary and high school students in the NCD found that despite in-school education about HIV/AIDS prevention and exposure to NHASP's national awareness campaigns, a significant proportion of students said they did not know how to get additional information on HIV/AIDS.[191]

To be effective in the reducing the spread of HIV/AIDS, education systems must eliminate school fees to keep girls in school, challenge gender stereotypes, provide life skills education that fosters mutual respect and equality between boys and girls, promote girls' leadership and self-esteem, eliminate sexual harassment, provide a secure and sanitary environment, and include age-appropriate information on sexual and reproductive health. This latter may be problematic in PNG, where the curriculum on Personal Development is broad based, and allows the teacher much personal discretion in presentation. Very promising is the recent commitment by the Department of Education to address HIV/AIDS issues through the education system. The policy for HIV and AIDS, supported by AusAID Education projects and the NHASP, was launched on World AIDS Day 2005.

Programmes to lessen women's disadvantage in employment, income-earning opportunities and rights to land and productive resources are crucial in the context of poverty and HIV/AIDS. Poverty, gender inequality and gender violence have been identified as the three main threats to women's protection from HIV/AIDS.[192] On the international Human Poverty Index, PNG was one of three countries ranked lowest out of 72 developing countries in 1999.[193] Since 1996 there has been a dramatic increase in poverty, with the number of Papua New Guineans living on less than US$1 a day estimated to have increased from 25% to 40%.[194]

Women and girls are the most affected by poverty, and this can be expected to worsen as the AIDS death toll rises and women are left to care for increasing numbers of orphans, as has happened in Africa. The ADB's 2002 Poverty Assessment of PNG observed that the plight of women had already worsened over the previous five years.[195] Already, vast numbers of women and girls, and some men and boys, are selling sex to meet their needs. In the consultations for this report, poverty was

[189] Cited in UNAIDS, UNFPA and UNIFEM 2004, *Key Facts and Figures on Gender and HIV/AIDS,* www.genderandaids.org
[190] As above.
[191] National Research Institute 2004, *Evaluation of the impact and effectiveness of the PNG HIV/AIDS awareness program in selected secondary schools and high schools in the NCD*, p 43.
[192] The Global Coalition on Women and AIDS, website homepage, www.womenandaids.unaids.org
[193] Schoeffel P. 2004, p 65.
[194] Jenkins C. 2005, p 9.
[195] ADB 2002, *PNG Participatory Poverty Assessment,* para 96.

mentioned continually as the biggest problem facing people in their daily lives, in rural as well as in urban areas. A focus on poverty alleviation strategies tailored to meet women's needs is urgently needed.

The usual strategy for improving women's economic situation – microfinance schemes for women – can be life-changing. The best approaches are based on an empowerment approach, incorporating life-skills training and collective solidarity, and addressing the risks to participants of increased marital violence as husbands try to control the loans or earnings.[196] An excellent model is the Intervention for Microfinance for AIDS and Gender Equity in South Africa.[197] This combines a poverty-targeted micro-lending scheme with a phased participatory 'learning and action' curriculum for participants (Sisters for Life). Continuous evaluation is integrated through the IMAGE study (registered with the Lancet), using control groups and assessing social, behavioural and biological outcomes, including HIV incidence.

Recommendation for consideration:

7. Prioritize strategies for empowering women and girls in the education andeconomic sectors.

[196] Bradley C. 1999, *Economic Development and Violence Against Women.* Paper for the World Bank.
[197] Full details, including manuals and evaluation tools: http:www.wits.ac.za/radar/IMAGE_study.htm

4. KEY ISSUES FOR NHASP

4.1 Introduction

This Section builds on Section 3's discussion of the broader issues related to a gendered approach to HIV/AIDS and identifies specific issues which can be addressed by NHASP during the remaining life of the Project. The aim is to strengthen the Project's ability to go beyond the "do no harm" minimum principle recommended by WHO (see Section 3.2), and develop programmes that not only respond to gender inequalities but attempt to transform them. This is being done quite well within NHASP at national level, but at provincial and district levels, and with NACS and other sectors, more support is needed. A table of the implications for NHASP of the recommendations of the Gender Audit of the NSP is provided as Annex 6, and the UNAIDS "Gender Sensitivity Checklist" for programmes and policies is attached as Annex 7.

4.2 Strengthening Capacity in Gender

Gender is still not well understood by most people in PNG, even by some who are involved in planning or implementing programmes incorporating a gender perspective. Gender still tends to be seen as "samting bilong ol mama", or "samting bilong ol waitman", and people new to the concept become confused when discussions that start off being about gender end up being about programmes for women. As discussed in Section 3.2, development of effective capacity in gender requires a sustained investment in technical support and skills training.

The Project needs to build on the gender awareness already created within its operations to develop the skills of partners and stakeholders in gender-sensitive planning, and competence in responding to gender issues such as violence against women, which affect implementation. During the next few months, the Project has the opportunity to strengthen its gender approach through activities which will require input from a specialist in gender and HIV/AIDS. Depending on the time and expertise available, tasks could include:

- assist Dr Clement Malau of the Burnett Institute in his capacity as Advisor to the Parliamentary Committee on HIV/AIDS, to mainstream gender jointly with HIV/AIDS in the activities of the Committee;[198]
- develop a "Gender and HIV/AIDS" information package and advocacy module for use with multi-sectoral partners and stakeholders;
- carry out a short participatory needs assessment exercise with the Advisor for C6, the four PLCs, and the HRCs, PCCs, PAC Chairpersons and Women's Representatives for Central and NCD, to identify how gender can be strengthened in existing provincial programming;[199]
- develop materials and approaches in response to the needs identified, pilot them in training with the above persons, evaluate and extend the training to other PACS, and provide ongoing mentoring;
- provide technical support in gender to ongoing district level strategic planning;
- advocate for and assist the formation of a gender mainstreaming management system in NHAPS and in NACS under the new structure, with one or more gender focal points at

[198] This recommendation has been discussed with Dr Malau and approved by him.
[199] NCD and Central Province are suggested because their Strategic Plans identified a variety of gender issues without developing programmes to address them, and also for practical reasons, since they will be easy to reach for follow-through and feedback on outcomes.

executive level taking responsibility for co-ordination and reporting on gender issues and activities in all focal areas of the NSP; provide ongoing mentoring and technical support to gender focal points and senior management;

- assist NACS to develop a long-term plan for sustained technical support and capacity development in gender;
- assist NACS to develop a gender equitable and gender sensitive working environment under its new structure and Corporate Plan, and ensure that all newly recruited staff receive a thorough orientation to gender in HIV/AIDS ;
- identify key gender issues relevant to each of NACS' Advisory Committees, and ensure that all members receive orientation to gender in HIV/AIDS overall;
- assist the proposed FBO Co-ordinator in the new NACS structure to ensure that gender equity concerns are fully integrated into approaches adopted with FBOs;
- work with NDOH to develop a plan for providing training in gender and HIV/AIDS and ongoing technical support in gender in the new approved structure for disease control;
- advise on gender issues related to the Transition Phase;
- assist as required with implementing other gender-related recommendations of this report.

Recommendations for consideration:

7. Recruit specialist technical support on gender and HIV/AIDS to strengthen the capacity of NHASP, NACS, NDOH and other sectoral partners for planning and implementing gender sensitive programmes.
8. Set up sex-disaggregated relational databases on participation in trainings, planning and implementation workshops, and committee memberships, that will allow levels of gender balance to be tracked through time and related to type of activity and location.
9. Revise and update the "Introduction to HIV/AIDS" course to tailor the gender sessions to the PNG situation, expand the human rights session to cover the HAMP Act, and develop a plan to ensure that gender, gender based violence and human rights will remain integrated into basic HIV/AIDS training in ways that will be sustainable beyond the life of the Project.[200]

4.3 Gender Based Violence

Gender based violence is both a cause and a consequence of the spread of HIV/AIDS.

The extent and forms of gender based violence in PNG were described in Section 1.5. The issues making it a major constraint in overcoming the epidemic were discussed in Section 3.4, and a summary of approaches recommended by WHO is attached as Annex 5. International experience has shown that when integrating gender into HIV/AIDS initiatives, it is important to also include gender based violence programming across the continuum of prevention to care, and at multiple levels.[201]

NHASP activities to date show an understanding of the significance of gender based violence for HIV/AIDS prevention and intervention, but the focus has been on raising awareness of

[200] Suggestions for these revisions and additions have been given in writing to the Advisor for C2, and discussed with her. The team are enthusiastic and have already planned to develop their response during the upcoming training evaluation workshop.

[201] IGWG and USAID 2004, *How to Integrate Gender into HIV/AIDS Programs: Using Lessons Learned from USAIDS and Partner Organisations.,* www.genderaids.org , topic of VAW.

the issues rather than on developing competence to address them. Basic training in HIV/AIDS as described in Section 2.3 includes some discussion of forms of gender violence, but this has not led to programmes to address the problem in the activities of PACs, HRS site committees or provincial strategic planning committees. Nor has the HIV/AIDS counselling training for volunteers or health workers developed skills in supporting clients at risk of violence.

Component 1's national awareness campaign on violence against women, linked with World AIDS Day 2004 and its theme of HIV/AIDS impact on women/girls, reportedly had some success in lowering acceptability among women of domestic violence (though less so amongst men).[202] However, rates are still lower than were found in the Law Reform Commission's research among similar groups in 1984-5.[203] The National Training Workshop for women's leaders also had some impact in preparing participants to conduct campaigns in their own provinces.

For the rest of the Project's life, it would be appropriate for NHASP to continue to promote awareness nationally, but add more focus on developing competence to respond to the problem, and on developing alliances with other donors and stakeholders. Suggested activities include:

- promote gender based violence reduction as a preventive measure against HIV/AIDs in multisectoral programming;[204]
- convene a workshop of stakeholders involved in counselling and care to develop approaches and tools for supporting persons diagnosed positive with HIV or STIs who fear violence, and integrate these into the training for counsellors, home-based carers and health workers. See also Section 4.5 on Partner Notification;
- investigate options for creating a network of lay counsellors to support VCT centres, antenatal and STI clinics, especially where violence is a risk;[205]
- include more skills-based coverage of gender based violence in Component 2 training manuals, to ensure continuity beyond the life of the Project;
- provide technical support on gender based violence to PACs, HRS site committees and provincial strategic planning committees;
- designate violence-free sex as a safer sex practice for the HRSS (see Section 4.4);
- liaise with the NDOH (Family Health, Clinical Services and Disease Control Branches) to introduce policy and protocols on sexual assault (building on background work done by UNFPA and FSVAC); formalise the pilot protocol on domestic violence (developed by the WCHP); and make PEP for HIV urgently available at all health facilities around the country (with Global Fund assistance);
- carry out awareness on PEP when it is introduced;

[202] 65% of women and 48% of men in an urban and peri-urban sample said wife-beating is not acceptable, whereas women had previously had the same rates as men, both lower (previous figures not specified) Marketsearch 2005, p 45.
[203] In the Law Reform Commission's research with urban low income groups in 1984-5, 75% of women and 58% of men stated that wide-beating was not acceptable. Figures for urban elite respondents were 64% for women and 59% for men. For rural women and men, the figures were 43% and 32% respectively. See PNG Law Reform Commission 1986, *Domestic Violence in Urban PNG,* Occasional Paper No. 19, p 24.
[204] Recommended by UNAIDS 2004, *Programme Coordinating Board Report on Women, Gender and AIDS.* December.
[205] Recommended by FHI, based on South African experience, in FHI 2001, *Voluntary Counselling and Testing, a Reference Guide: Who is Doing What on VCT?* , p 101.

- disseminate widely to stakeholders the results of HRSS surveillance on gender violence related indicators, and of Component 2's current study on violence associated with a positive diagnosis of HIV among antenatal women;
- liaise with UNAIDS to develop a plan for promoting the proposed gender violence advocacy manual with HIV/AIDS stakeholders;
- develop a closer working relationship with FSVAC and distribute their materials on domestic violence, rape, other sexual offences, women's legal rights to maintenance and custody of children, and the "Stap Isi" video on domestic violence to PACs and other stakeholders;
- investigate producing a video on violence against women and children, including rape in marriage, for use with stakeholders, particularly FBOs;
- involve men (see Section 4.8);
- consider implementing Recommendation 12 of UNICEF's recent report on child sexual abuse and sexual exploitation.[206]

Recommendation for consideration:

Promote the reduction of gender based violence as a preventive measure against HIV/AIDS, increase the competence of NHASP, NACS and multisectoral stakeholders at all levels to integrate responses to gender based violence, including child sexual abuse, into programming, develop alliances with other donors and stakeholders, and continue to raise awareness of the issues among the general public.

4.4 High Risk Setting Strategy (HRSS)

The HRSS was developed by NHASP and NACS during 2004-5 to meet the need identified in the strategic plans of both organizations for targeted interventions to "facilitate and sustain behaviour change to minimize HIV/AIDS and STI transmission and increase awareness in high risk settings in PNG".[207] Five groups have been prioritised: Group 1, settings where "people negotiate for sex"; Group 2, Highlands Highway and the ports of Lae and Madang; Group 3, disciplinary forces (Defence, Police, CIS and security firms); Group 4, private industries (mining and petroleum sites, fisheries and canneries, construction sites, palm oil

[206] "Recommendation 12: Training standards and a code of conduct for all HIV/AIDS workers.
This recommendation addresses the findings of this study that employees, volunteers and peer educators associated with various HIV/AIDS programs, who have gained access to communities of sex workers and brothels, are in come cases becoming perpetrators themselves or mixing safe sex messages with activities that commoditize children, especially girl children.
- that NACS, the NHASP, the EU Sexual Health Project and all PACs and UN agencies:
- develop in-service and pre-service courses for all HIV/AIDS peer educators and counsellors on Child Rights, provisions of the Constitution and domestic laws on CSA and CSEC;
- develop and AIDS workers' code of conduct for all registered peer educators, sexual health counsellors and AIDS counsellors relating to the relationship between peer educators/counsellors and their clients, prohibiting involvement of peer educators and counsellors in CSA or CSEC, with a clear stand on issues of polygamy, brideprice and child brides , involving church workers and children, and putting into place appropriate mechanisms for breaching that code of conduct;
- train AIDS peer educators and counsellors to recognise indicators of CSA and CSEC and how to make appropriate referrals where criminal offences are concerned, without breaching principles of trust and confidentiality."
From UNICEF and HELP Resources 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Exploitation of Children in PNG.* Draft, January.

[207] NHASP 2004 July, *HRSS Framework.*

estates); and Group 5, youth at risk in the NCD (in and out of school youth, the unemployed, and youth involved in the sex trade).

The operational approach of the strategy is top-down driven by NACS/NHASP, with a bottom-up response from stakeholders involved in prevention programmes. Co-ordination of activities is through local High Risk Site Committees of trained volunteers, supported by the PACs and by four national HRS Co-ordinators. The principal strategy is behaviour change through peer education, in an enabling environment supported by four "pillars": full access to condoms, VCT, referral for STI treatment, and care and support to people living with HIV/AIDS. Work has begun in 31 pilot sites in 10 provinces, to be expanded to four more provinces by the end of the year, and a further three by July 2006. As NHASP's C1 national campaigns are phased out, the HRSS peer education materials development strategy will become a major focus for behaviour change to reduce the spread of the epidemic.

The HRSS is conceptualised as an emergency response, but it is perfectly possible for it to fulfil that mandate in ways that also support a reduction in the gender inequalities that create the conditions for high risk behaviours and fuel the epidemic. From a gender point of view, there are a number of problems, both conceptual and operational, associated with a major emphasis on high risk settings/groups in the context of a generalised epidemic, where everyone is at risk and the multisectoral mainstreaming of HIV/AIDS approach calls on everyone to participate in prevention.

The change to "settings" replaces previous terminology of high risk "groups" and "behaviours", with the intention of minimising the stigmatisation of the beneficiaries of interventions. However, it has been found that "settings" can also become stigmatised, and in any case, all activities are directed at identified "target populations", with the dangers of continued stigmatisation that that entails.[208]

Existing gender bias in the culture and the sexual double standard mean that women involved in the sex trade, and village girls dubbed as "promiscuous", are seen as "agents of infection", whereas the men who use their sexual services are not stigmatised in the same way. The regular male partners of sex workers are included in interventions (conceptually, at least), but the regular female partners of the men who use sex workers or have multiple other partners receive inadequate attention. In practical terms they may be harder to reach, but the main fault must lie in the fact that the HRSS strategic objective only focuses on members of the HRS target populations and does not specify their partners (see below).

A focus on geographic or work-related "settings" draws attention away from the context of unequal gender relations that underpins and perpetuates high risk behaviours and determines the options that women and men have for responding to the ABC messages directed at them by the HRSS. Marriage is not identified as a "high risk setting" for women, despite evidence that "housewives" comprise one of the largest risk categories of infection, as discussed in Section 3.3. Sexual coercion is not classified as a high risk behaviour, although rough sex, especially with young persons, increases the risk of transmission of HIV and STIs. Equality in sexual decision-making is not included as one of the pillars of an enabling environment. In fact, the use of the term "negotiating" for sex in the title for Group 1 masks the underlying dynamics of unequal power that are really involved.

The conceptualisation of high risk behaviours as taking place primarily in high risk settings narrows the concept of "risk", and underplays the extent to which persons in high risk settings also have sex with other people outside those settings. Nor is "negotiated sex" something that only sex-workers in "risk settings" are involved in - many married as well as

[208] Lepani K. 2004 December, *HIV/AIDS High Risk Settings Strategy, Focal Point Project Analysis, Draft Concept Paper.* Save the Children in PNG, p 6

single women have sex for money or goods. Many men who have sex with men also have sex with women[209], and many married men have sex with multiple concurrent partners and/or sex workers. Operationally, it is vital to take these overlapping sexual networks into account, and reach the regular partners with whom members of HRS target populations also have sex.

WHO guidelines recommend that for sub-populations with rates of HIV prevalence over 5%, particular attention should be paid to behavioural connections between members of these groups and the general population – known as "bridge groups".[210] The HRSS M & E draft framework acknowledges this, yet operationally, HRSS's strategic objective is defined as "to increase safer sex practices among members of the HRRS groups"[211], and their partners are not included. Of course, if the BCC programmes of the HRSS succeed in achieving full compliance with safer sex practices on the part of the targeted high risk populations, their other partners will thereby be protected. In the meantime, it is essential to enable those partners to take measures for their own protection.

There are a number of other indications that the HRSS does not yet pay sufficient attention to the role of unequal gender relations in the spread of HIV/AIDS, and to the need to enable women to protect themselves rather than just being the recipients of male-oriented ABC messages. Some examples are:

- male dominance of HRS site committees. Despite a directive that there should be one-third female representation, several committees have no female member (e.g. ports and fisheries, army barracks), leaving the interests of wives, female staff and sex workers unrepresented.[212] A study tour for the Defence Force HRS committee to Laos and Cambodia did not include a representative of soldiers' wives;
- male dominance in BCC training. Of the HRS site committee members trained (excluding NHASP staff facilitators), only one in four is female;
- operational plans for Groups 2 and 3 concentrate on condom distribution to male workers and female sex workers, show little involvement of the wives of workers, no attempt to address gender violence, and no development of women's leadership;[213]
- condom distribution activities are disproportionately aimed at female sex workers rather than their male clients, both reflecting and reinforcing stigmatisation of these women;[214]
- sexual double standard and blaming of women, e.g. one site committee asked local village court magistrates to take action against married women having affairs, but not against married men doing the same; [215]
- inadequate response to workplace issues affecting women's risk of HIV/AIDS. For example, the HRS plan for a major tuna canning factory, 80% of whose workforce of 3,500 comprises illiterate young women aged 16 to 25, has no representation of these women on the HRS site committee, no sexual harassment policy, and no counselling or support service or prevention plan on rape, despite acknowledging that its shift hours and

[209] 72%, according to the IMR, FHI, SCiPNG study, 2005.
[210] NHASP 2005 July, *Draft Guidelines for Monitoring, Evaluation and Surveillance Plan for HRSS.*
[211] FHI 2004, *Behaviour Change Communication Training Manual for PNG HRSS*, p49.
[212] In some cases, a place is reserved for one female sex worker, but this is only a token, not meaningful representation, especially where all or most of the other members are male.
[213] Operational plans made available were: Igam Barracks, Lae Ports and Lutheran Shipping, Lae Ports and Main Wharf, Umi Market, Yang Creek 1, Yang Creek 2,
[214] One HRS Site Co-ordinator was sufficiently insensitive to stigma issues as to put a photograph of some of the female sex workers in their area on the front cover of the Committee's Operational Plan.
[215] Stootick Kamya, Chair of RD Tuna HRS Committee, personal communication.

system for worker transportation result in many girls being raped, and that girls are exposed to sexual harassment from supervisors and security guards at the plant;

- the BCC training manual does not include background on gender and gender violence issues, uses male-dominated language and examples, and bases its training for planning and implementation on gender-blind categories (e.g. "people", "youth", "adult population", "community");[216]
- the Monitoring, Evaluation and Surveillance Plan does not specify that data will be collected and analysed by gender (with the exception of data on female sex workers and their clients, and four questions on the sexual behaviour of young males and females).

It is important to strengthen gender sensitivity as much as possible from the top down, to counteract the risk of increased gender bias that is likely to occur as the move is made towards bottom-up development of BCC strategies and materials led by the local HRS site committees. Increased use of dialogue-based approaches carries the risk that local religious views and punishment/fear-based messages will have more influence,[217] that gender stereotypes will be reinforced rather than challenged, that woman-blaming attitudes will predominate, and that tighter male control of the behaviour of women's and girls' behaviour will be seen as part of the answer rather than part of the problem.

Use of community theatre groups in awareness strategies, although very popular, poses particular problems for ensuring consistent and gender equality messages.[218] The Project is aware of these problems, and groups trained so far have been authorised to use only approved scripts. The discussion in Section 3.3 of the gender deficiencies of the ABC approach on which the HRSS and its BCC strategies are based is particularly relevant here. More tightly designed targeting of messages will be needed to avoid unintended negative consequences, such as the reinforcing of tendencies to blame young women's lifestyles for the spread of HIV/AIDS when images of westernised young women intended to appeal to urban populations are used in posters that are also distributed in rural areas.

Finally, there needs to be a broader concept of behaviour change. Rather than concentrating solely on minimising risky sexual behaviours, the HRSS needs to actively promote a more positive, egalitarian and coercion-free sexuality. For example, BCC training offers a valuable opportunity for at least introducing a healthier approach to sexuality. Training already mentions non-penetrative sexual activities as less risky alternatives to intercourse, and the discussion could be broadened to explore consensual sex for mutual pleasure, and the role of sexuality in relationship building.

Without a commitment to addressing the gender inequalities associated with high risk behaviours, much of the potential power of the HRSS will be lost. Implementers will be satisfied with persuading rapists to wear condoms, for example, rather than aiming to reduce rape. The UNICEF study on child sexual abuse and exploitation cites an example of exactly this, where an AIDS worker was present when two security guards were planning to rape a drunken sex worker. The AIDS worker did not attempt to stop the rape, but gave the men

[216] Suggestions on how to improve gender and cultural sensitivity in BCC training have already been given in writing to the Advisor for HRSS and to FHI.
[217] 71% of people surveyed by Marketsearch in 2005 agreed with the statement "I think people with HIV/AIDS have probably got it through their own bad behaviour and deserve what they get". Marketsearch 2005, p 27
[218] Mcpherson N. 2005, *SikAIDS: Deconstructing the Awareness Campaign in Rural West New Briatin, PNG.* Draft chapter for forthcoming publication by ANU on HIV/AIDS in PNG. This paper describes the misinformation and gender bias that can permeate trained community theatre groups, and the negative reactions of rural villagers to posters designed for more urban oriented audiences.

condoms instead, and reported this as a successful intervention at a later workshop on care and counselling.[219]

Recommendations for consideration:

Increase the gender sensitivity of the HRSS at the conceptual level by extending the strategic objective to include the partners of members of the HRSS groups; identifying the need to go beyond safer sex messages (ABC) if women (particularly married women) and girls are to be able to practice safer sex; emphasizing gender violence as a high risk behaviour for the spread of HIV/AIDS, and egalitarian, coercion-free sexuality as safer sex behaviour; and recognise greater gender equality as one of the pillars of an enabling environment.

Increase the gender sensitivity of the HRSS at the operational level by: ensuring that training and programming support the ABC approach by addressing the social, cultural and economic factors which restrict women's and girls' ability to practice safer sex and highlighting the particular needs of married women; avoiding an overemphasis on females as vectors of the disease and promoting more equitable gender relations; reducing male dominance in decision-making and training; introducing programmes to reduce gender violence, in communities as well as in workplaces; adjusting BCC training to include in-depth discussion of gender issues, gender violence, and egalitarian, violence-free sexuality; and ensuring that all monitoring, evaluation and surveillance collects and analyses data by gender.

4.5 Partner Notification for STIs and HIV

Partner notification in cases of STIs and/or HIV sero-positivity is an important gender issue that has not yet been adequately addressed. Because of their economic dependence and lower status, women revealing their positive test results to their partner can face much more severe consequences than men in a similar situation. Women who know they risk an angry or violent reaction, or abandonment, often choose to not tell their partner of their diagnosis. Usually, this means the woman becomes reinfected with the STI, and that the infected partners continue to spread the STI, or HIV, to others. If she is pregnant and HIV positive, it also puts the baby at risk of HIV infection from the mother.

No hard data exist for PNG, but a study in Kenya found that only 27% of HIV positive women disclosed their status to their partner, and of these, one third suffered severe consequences – abandonment, beating and suicide.[220] What is currently known for PNG is that one in five women does not even go back for the results of her HIV test, as was found by the most recent survey evaluating the Project's national social marketing campaign.[221]

This issue of partner notification (or partner management, as it is termed by NDOH), arises in STI clinics, antenatal clinics, VCT centres, in primary health care settings where CHWs have now been trained to do syndromic management of STIs, and at PMGH's HIV/AIDS clinic and social work department. Health workers interviewed for this report stated that men do not usually express difficulties about notifying their wives or other sexual partners, but that women often express anxiety about telling their permanent partners. Women who have casual partners have less trouble telling them, but there are no records on whether they actually do.

For STIs, standard procedure is that a note should be given to the diagnosed person to give to her/his partner(s), stating that the recipient has been exposed to a communicable disease, and

[219] UNICEF and HELP Resources 2005, p 18. Draft, January.
[220] From Heise et al 1999, *Population Report: Ending Violence Against Women*, p 16.
[221] Marketsearch 2005, p 45.

is asked to come and see the health worker, bringing the note. A code on the note allows it to be linked to the original case, so that in theory, tracking is possible. In practice, there is no follow-through.

Although the purpose of the note is to spare the diagnosed person from having to break the news themselves, in reality, a husband receiving such a note knows what it means and can become immediately enraged. Health workers and social workers interviewed for this report guessed that perhaps over a third of married women diagnosed were not telling their husbands about their STI or HIV status, for reasons illustrated in the text box below.

Comments on women's difficulty in disclosing HIV or STI status:

"*It's especially hard for a married woman. In most cases, the husband will blame her, and who knows what he'll do? – maybe physical violence, or throw her out – even if he really knows she got it from him".* NHASP/NDOH Sexual Health Advisor, discussing STIs. (cont.d)

"Most HIV positive antenatal mums don't tell their husbands for fear of being belted up, or fear that they might be thrown out, or fear of disharmony among them. Or they are just fearful, they don't know how their husbands will react, so they keep it to themselves". Social Worker, PMGH.

"*It's a very difficult situation, because culturally, couples don't have a habit of good communication, especially about sex. Problems tend to be solved by the fist, not by the mouth".* VCT counsellor, Madang.

" Looking at the cultural point of view, we women are just nothing. They look down on us, where they say 'Who are you to tell me I have to go and get tested?' The family too will be all against her. The mothers and the sisters and everyone on the husband's side will all blame her. They'll say it's her fault, she got it from someone else". Sister in Charge, STI Clinic, Goroka Base Hospital.

"*The women fear for their lives when the husband finds out she's got a disease. The next thing he does is go out and get a new woman. So the poor wife is fighting for her rights, should she try and keep him or go out and try and get a new one. And the Highlands men are the worst, they always blame the woman."* Infection Control Nurse, Goroka Base Hospital.

When a woman is tested HIV positive in a clinical setting (STI or antenatal), she is normally referred to a doctor to receive her diagnosis, and is then asked to tell her husband to come in for testing and counselling. If a woman believes she was infected by her own husband, there is little incentive to tell him, because the only ones who would benefit from his knowing would be her husband's other partners, and their partners, assuming he then decided to practice safer sex. This situation may improve once ART becomes more widely available.

In an antenatal setting, there is more incentive for a woman to tell her partner, because this will help her to prevent transmission to the baby by receiving treatment at the time of birth and by either formula-feeding the baby, or by ceasing breastfeeding early. However, this does not seem to be happening consistently, because protecting the baby would make the mother's HIV status obvious, and women fear this consequence for themselves and their existing children. It is also possible that some women diagnosed with HIV at an antenatal clinic choose not to give birth in a health facility, in order to conceal their HIV status. Of the 37 new HIV positive cases recorded by the Nurse Counsellor at PMGH Antenatal Clinic

between January and August 2005, only six had notified their husbands.[222] These figures are kept only in a notebook in the Nurse Counsellor's pocket. There is no formal recording system at this time.

A doctor's letter is available, in English and Tok Pisin, for a woman diagnosed with HIV to take to her partner, but this does not appear to be helpful. Only two women accepted the letter, and neither of them then gave it to their husbands. PMGH is the only hospital in the country with trained social workers, but their workload is enormous, and it is not possible for them to follow up on more than a tiny proportion of cases.

For HIV, there are legal implications for notification, stemming from the HAMP Act of 2003. Under this Act, a person has the right to confidentiality about their HIV status. However, it is illegal to inform a person of the result of their own HIV test without also informing them of their duty to tell their sexual partners about the test result. A person providing counselling, care or treatment to the HIV-positive client does **not** have a legal obligation to notify the sexual partners, but **may** notify the partner(s) if they are requested to do so by that HIV positive person, or if they have reason to believe that the person has not told their partners and that there is a real risk of transmission of HIV. Intentional transmission of HIV can be prosecuted under the *Criminal Code* under a range of offences, some of which carry sentencing options of up to life imprisonment. As yet, no such prosecutions have been initiated.

At present, HIV positive women are disadvantaged in that they are legally required to notify their partners and may be liable to criminal prosecution if they do not do so. Yet no support is provided to them in notifying their partners, a course of action which may be more immediately detrimental to them than the diagnosis itself. Currently, neither the training for VCT counsellors (including health workers) nor the checklist and handbook for conducting post-test counselling offer practical guidance on this situation.

There is a need to develop realistic policy and procedures for partner notification, with training, that take into account women's additional vulnerabilities, and to provide practical support. This is necessary also for reducing the transmission of HIV from mother to child. Currently, the Project is funding a study, due to begin later this year, on marital violence in women who tested positive for HIV, and this should provide valuable information on which to base the development of interventions.

Options relating to policy include:

- actively encouraging **voluntary** pre- and post-testing and counselling of couples jointly. Experience elsewhere has shown that joint testing and counselling can reduce the negative consequences for women of disclosing sero-positivity to their regular partner, and can improve women's adherence to PTCT interventions.[223] For success, this would require sustained promotional activities, and a specialised focus in training;
- when children show clinical symptoms suggesting HIV infection, requiring simultaneous testing for both parents at the same time, and giving out test results to both together. In Zambia, this has been found to reduce blaming and violence.[224]
- linking with the Project-funded upcoming upgrade to PMGH antenatal clinic to pilot an approach to improving partner notification and monitoring that could inform policy development by NDOH.[225]

[222] Sr Appolonia Yauieb, Nurse Counsellor, PMGH Antenatal Clinic, personal communication.
[223] Family Health International 2001, *Voluntary Counseling and Testing, a Reference Guide*: *Who is Doing What on HIV/AIDS?* P 100.
[224] Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach.*

Possibilities for improving support include:

- convening a workshop of persons involved in counselling and care, to share experiences and develop approaches and tools for improving the rates of partner notification while protecting the rights and safety of infected persons;
- revising Component 2's training manual, checklist and handbook on VCT to cover the HAMP Act, and ensure that sufficient guidance is given to counsellors to enable them to minimise the effects on HIV positive persons, especially women, of notifying their partners of their HIV status;
- linking with and further developing the protocol for responding to domestic violence cases piloted by the NDOH WCHP, under which health workers were trained to develop a community support network for referral purposes;
- linking with the LJSP's training programme for village court magistrates to encourage them to issue a Preventive Order to a woman who fears violence from her husband because of a diagnosis of an STI or HIV, and discouraging them from pressing compensation claims by men against wives who did not notify them;
- creating a low-literacy leaflet (similar to that produced on domestic violence through the WCHP) suggesting ways for a woman to handle telling her husband/partner and find sources of support in her community, to be given out by counsellors and health workers;
- greatly expanding the network of lay/volunteer counsellors to provide longer-term support to persons receiving a positive diagnosis, especially women;[226]
- liaising with FBOs to promote **voluntary** couple counselling and testing, as a way of strengthening communication in and commitment to marriage, and conducting a national awareness campaign through Component 1.

Recommendation for consideration:

Develop policy, procedures and training on partner notification for STIs and HIV, that take the different realities of women, men, boys and girls into account, ensuring that women are not additionally victimised by the legal requirements for partner notification under the HAMP Act; and liaise with NDOH to give priority to this issue under the new structure for Disease Control.

4.6 Condom Policy

During its life so far, the Project has distributed over 5 million male condoms, but only about 400,000 thousand female condoms. All are distributed free. Male condoms are distributed to health services by the NDOH, and otherwise through CSOs and through the PACs. In September this year, provinces were supplied with male condom dispensing machines. Female condoms are distributed to PACS, and to NGOs working with commercial sex workers and men who have sex with men. A study on the relative effectiveness of these methods of distribution in reaching the men and women who want to use them is planned for the final year of the Project.

Male condom use is low in PNG. Even in urban areas where they are more easily available, a survey this year found that only 60% of males and 30 % of females had ever used one, and

[225] This has been suggested by Dr Grace Kariwiga, chief obstetrician at PMGH antenatal clinic.
[226] A South African example of a lay counselling service is described in Family Health International 2001, *Voluntary Counseling and Testing, a Reference Guide*: *Who is Doing What on HIV/AIDS?* p102.

some women did not even know what a condom was.[227] Only the male condom has been promoted by the Project's national campaigns. Until this year, condom use messages were aimed mainly at men, recognising that men normally control the conditions of sexual relations. Protection for women relied on men making safer choices.

What is needed is a shift in approach that will assist women in making their own safer choices. Assuming they do not need to get pregnant,[228] women face two barriers to using male condoms: access, and negotiating use. In a marriage or regular partnership, the suggestion of condom use implies infidelity on the part of one or both partners, and can cause an angry or violent response, even abandonment. Women's economic dependence makes this a difficult barrier to address, but examples from other countries that offer promise are: national campaigns that portray condoms as the choice of "couples who care" (Zimbabwe),[229] and that explicitly promote the initiation of condom use by women (Vanuatu),[230] and the active promotion of female condoms (Zimbabwe).[231]

There is also a valuable body of knowledge about how to increase PNG sex workers' ability to negotiate condom use with clients that could be used in practical skills-building workshops with single and married women.[232] Two studies piloting the female condom in PNG found high levels of acceptability amongst both males and females.[233]

The female condom is often referred to in the international literature as a "female controlled method of prevention". This is not strictly true, because under most circumstances the man must still agree. Its external ring is visible and can be felt, and it can sometimes squeak during intercourse, but a study in Zimbabwe found that 13% of female users reported using the female condom without their partner's knowledge.[234] Anecdotal evidence in PNG suggests that it can be used without negotiation where the man is in a hurry, if he is drunk, or if it is a rape or gang rape situation (provided the woman had pre-inserted the condom, which more women are doing if they know they are going into dangerous situations).

There are other advantages. It is easier to get male agreement because the female condom can be put in place in advance (up to 8 hours); negotiation can centre on which condom – male or female? – rather than male condom or no condom; it is well lubricated, which PNG men appreciate; it cannot slip off if the man loses his erection; and is more convenient during menstruation. It can also be reused, if washed in a certain way.[235] Most importantly, however, it introduces the idea, to men as well as women, that women can have "sexual agency" (make their own decisions about sex) and have their "own" condom, and this is a vital step in bringing about safer and more equal sexual relations.

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[227] Marketsearch 2005, p 42.

[228] A microbicide spray that will prevent HIV and STI transmission but also allow conception is being developed, but is several years away from being available for public use. Interagency Coalition on AIDS and Development 2003, *HIV/AIDS and Prevention Options for Women.* www.icad-cisd.com

[229] Described in Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach, p 92.*

[230] Posters show a "respectable" woman smiling lovingly at her partner while offering him a condom.

[231] Commonwealth Secretariat 2002, p 92

[232] See SCiPNG and FHI 2004 October, *Working with Female Sex Workers in PNG: A Training Curriculum for Poro Sapot Outreach Workers, Working Draft,* especially pages 83-88.

[233] Jenkins C. 1995, *A study of the acceptability of the female condom in urban PNG.* PNG IMR Report. Russell D and Passey M 1999, *Monitoring the distribution and use of the female condom in urban PNG.* Report of the PNG IMR.

[234] Commonwealth Secretariat 2002, p 94.

[235] WHO recommends a new female condom for each act of intercourse, but if this is impossible, it has a protocol for re-use. For more information, see: www.who.int/reproductive-health/rtis/reuse.en.html

A UNFPA mission on female condom programming in the Pacific recently consulted with stakeholders in PNG and has recommended the upscaling of female condom distribution.[236] It will be promoted as a dual protection method, i.e. against STIs/HIV as well as pregnancy. Phase 1 will initially target vulnerable groups: women attending STI clinics, women in violent relationships, women with a positive diagnosis of HIV, commercial sex workers and men who have sex with men. Female condoms are expensive, however, so expansion to the rest of the female population will depend on the availability of adequate funding. The Global Fund is expected to provide assistance with this.

Current barriers for women's access to both female and male condoms need to be addressed urgently. Supplies of female condoms must be vastly increased, and women's networks must be used for distributing both kinds, and for training women to negotiate for and use them with confidence. Young women must be particularly targeted for training, and younger girls should be made aware of the female condom's value for when they later become sexually active. There is no evidence that knowledge about safer sex and contraception encourages premature sexual activity.

The placement of dispensing machines for male condoms must consider women's needs as well as men's. At present, guidelines state that the machines should be installed in strategic locations accessible by the "general public". Large dispensers must be installed in a covered location, and small dispensers can be placed in any location which is accessible to "many people" and which can also enable regular checks for re-filling. Use of the generic terms "general public" and "many people", means that the particular needs of women are not required to be considered during placement. Some smaller dispensers have been placed in less visible places such as the toilets of workplaces, but the majority of large dispensers have been placed in highly visible places, such as the main entrances of hospitals, government offices and other public buildings, which makes it difficult, if not impossible, for anyone to access them discreetly.

If the guidelines required the dispensers to consider the needs of women and girls for placement in areas with more privacy, embarrassment need not deter women from using them. An example is the dispensing machine at NHASP/NACS headquarters. It has been installed in the entrance opposite the check-in desk, less than six feet from and in full view of the male security staff and waiting visitors. Moving it to the first landing of the stairs, just ten feet higher, would allow it to be accessed discreetly.

Recommendations for consideration:

15. Conduct an evaluation of the effectiveness of current male and female condom distribution systems in reaching rural men and women and male and female youth, particularly in rural areas.

Make the promotion of women's sexual agency an explicit goal of NHASP's policy on condoms and implement strategies to achieve this, including greatly increased distribution of female condoms outside the commercial sex work context.

4.7 Women's Leadership

As more and more women become infected with HIV, there is a need for women to take a greater role in prevention education, including condom distribution and training in negotiation skills, with women and girls; in reducing the burden of stigma and discrimination against women with HIV/AIDS; in mobilising against gender violence and other inequalities that increase women's vulnerability; in promoting women's right to protect themselves

[236] UNFPA 2005 June, *UNFPA Mission on Female Condom Programming in the Pacific: PNG.*

against HIV/AIDS; and in advocating publicly for more responsible male behaviour. So far, this kind of leadership has been scarce.

Leadership is a relatively new arena for PNG women. There are a few pockets of gender-aware, pro-woman leadership, but overall, the country is lacking an active women's movement with experience in advocacy for change. It does have an extensive network of community-based women's clubs and church groups, many dating from colonial times, but these are oriented towards women's domestic and moral duties as wives and mothers. They tend to support male dominance, blame women for the spread of HIV/AIDS, and link condoms with increased promiscuity, stressing abstinence and fidelity without addressing the inequalities that prevent women from protecting themselves against HIV/AIDS.

The National Council of Women (NCW) was set up at Independence as the official umbrella group for all women's organizations in the country. With its network of Provincial Councils of Women (PCWs) and District Women's Associations (DWAs), it appears to be the ideal organization for spearheading national leadership by women on HIV/AIDS. However, it is under-resourced in funding and personnel, has a poor track record on financial reporting, has low capacity in gender, has been frequently disrupted by public feuding between leaders at both national and provincial levels, is dominated by a small number of older women who have rotated in and out of power for the last two decades, and lacks any outreach among younger women. NHASP's proposed National Training Workshop for NCW leaders did not eventuate as no firm commitments could be given by the NCW leadership. The project is now planning to develop a leadership program by selecting women in key spheres of influence rather than NCW.

At provincial level there is an over-concentration of power in the hands of the President of the PCW, who is usually also the Women's Representative on the Provincial Assembly as well as the Women's Representative on the PAC. PCW executive members get preference for provincial, regional and national trainings and workshops, and some of the PCW leaders interviewed for this report had been to so many in the last two years that they had lost track. On the plus side, a few PCWs have done sterling work at times over the years, such as in East New Britain, Morobe and East Sepik.

There is a need to broaden the Project's outreach and involve women's leaders from all sectors at national, provincial and district levels. Some possibilities for involvement are:

- women agricultural extension officers. This is a recommended best practice by the Commonwealth Secretariat[237] and is particularly appropriate for PNG, where 84% of women are involved in food production.[238] Every province has several women agricultural extension officers, and they are also organised into a national association. Those who were interviewed for this report were eager to become involved.
- women's professional associations, e.g. the Teachers' Federation, Business and Professional Women's Association, the Secretaries Association, the University Women's Federation, the Nurses Association (whose recent Symposium on HIV/AID was funded partially by the Project), and women's wings of trade unions;
- Women in Politics, and the increasing number of women candidates, now in the hundreds, who have stood (though unsuccessfully so far) in the last two national elections;

[237] Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach, p* 66.
[238] Schoeffel P. 2004 October, *Pacific Strategy 2005-2009: Gender Strategy for the Pacific.* ADB Report, p 7.

- prominent women public servants, lawyers, academics, business women, social activists, sportswomen, and the wives of male public figures;
- District Women's Facilitators for Education, trained by Education Department as advocates for girls' education, and operational now in every District;
- sports associations, such as softball, netball and soccer, perhaps including promotional items such as armbands or T-shirts with slogans such as "Sportswomen support safe sex".

As well as reaching a broader cross-section of women's leaders, there is a need for suitable materials for them to use. The National Training Workshop for Women's Leaders held in 2004 did not result in a manual. An advocacy manual on gender, human rights and HIV/AIDS for use with women's organizations and other CSOs should therefore be developed.

Recommendation for consideration:

17. Create a broad network of leaders of women's and young women's organizations from all sectors, and of women in influential positions, to be trained and resourced as advocates for promoting the protection of women and girls from HIV/AIDS, and for reducing the inequalities that prevent them from protecting themselves.

4.8 Involving Men

The broad issues relating to increasing men's involvement were discussed at length in Section 3.5. NHASP has already made efforts to increase men's involvement in prevention and care, such as through training males as role models, and encouraging men to share women's workload, especially in home-based care, as has been described in earlier sections. Other suggested activities for the period remaining are:

- continue to fund selected males to attend training at the Fiji Women's Crisis Centre;
- develop a network/support group of male role models or "champions" for equality, based on the men already trained in Fiji, other male trainers, and linked with Men Against Violence and other organizations involved in men's reproductive health (e.g. UNFPA's 1990's initiative on Men as Partners).[239] The NAC Advisor for Care and Counselling, a male, has enthusiasm for gender issues and could perhaps take the lead on this;
- promote the Black Thursdays movement in the country, in memory of female victims of male violence. Normally this involves wearing black clothes, but a black armband, with a slogan or logo, would be more practical and effective. The men's network could take this on;
- identify some appropriate male national opinion leaders to be profiled in media campaigns (as was successfully done during the Law Reform Commission's campaigns on domestic violence, which involved the Police Commissioner, the Prime Minister and his wife, and others);
- include positive messages about responsible, respectful, consensual and mutually satisfying sexual relationships in presentations on sexual behaviour, not just negative messages about risk behaviours or information about non-penetrative sexual techniques;
- address homophobia in the context of human rights and HIV/AIDS in trainings and programming;

[239] See contact information on Robert Titi and Max Tineka in Annex 3, and relevant footnote in Section 3.5.

- encourage the NDOH, FBOs and women's organizations, to actively promote men's attendance at childbirth (this is allowed, but not promoted, under NDOH policy), and also **voluntary** joint testing for HIV/AIDS (see Section 4.5);
- liaise with FBOs to encourage couples to sit together in church, instead of on opposite sides of the building, and to promote fathers' role in child-care and care-giving;
- encourage men to participate in food crop production, especially managing home gardens for growing nutrient supplements for those infected with HIV/AIDS.[240]

Recommendation for consideration:

18. Strengthen men's sense of responsibility for reducing the impact of HIV/AIDS on women and children by providing role models, leadership skills and structures, promoting healthy consensual sexuality, shared parenting, and more equal gender relations.

4.9 Surveillance and Reporting

Although some problems remain with both sero and behavioural surveillance, the Project has made considerable achievements in this area in the last five years. When the Project started, there was no sentinel surveillance at all. Now there are 26 sentinel sites giving good quality sero data, and behavioural data collection has been begun, using internationally developed tools. All national sero and behavioural data are sex disaggregated. As the VCT sites roll out, they will enrich the national data by providing information from the non-clinical sites, which had been contracted out to the PNG IMR while the national system was developing.

Many of the current gaps relating to gender data will be remedied in the new surveillance protocol which will be used by the HRSS, provided all data are collected and analysed disaggregated by gender.[241] Indicators will be used which will measure and track some of the gender factors influencing risk in the general population (aged 15-49) and among young people (15-24). As well as the usual indicators on knowledge, beliefs and sexual practices, questions will be asked on attitudes towards sexual negotiation[242] and, for young people only, on age at first penetrative sex, age-mixing in non-marital sexual relationships,[243] sexual coercion,[244] and sexual negotiation skills.[245]

The biggest gap remaining relates to the role that marriage plays as either a risk or protective factor for HIV transmission.[246] See Section 3.3 for more background on this issue. For advocacy purposes, it would be useful to know what proportion of HIV infected women were "faithful wives", to dispel some of the stigma attached to infection, particularly by FBOs, and to reduce resistance to condom promotion. For programming purposes, it would be useful to know what proportion of married women have been involved in extramarital sex, especially for reasons of economic necessity. Numerous organisations target commercial sex workers,

[240] Recommended best practice by the Commonwealth Secretariat 2002, *Gender Mainstreaming in HIV/AIDS: A Multisectoral Approach,* p 67.
[241] NHASP 2005 July, *Draft Guidelines for Monitoring, Evaluation and Surveillance Plan for HRSS.*
[242] % of people who believe that, if her husband has an STI, a wife can either refuse to have sex with him or propose condom use.
[243] % of young women who have had **non-marital** sex with a man 10 or more years older, in last 12 months.
[244] % young men believing violence/threats are acceptable ways of getting sex, and % of young women who have been forced to have sex.
[245] % of young women who have successfully refused to have sex without a condom or have successfully insisted on condom use; % of young **single** people having sex for money or gifts in last 12 months;% of young people using condom at first sex.
[246] "Marriage" would include relationships where the partners co-habit as if married.

but few stakeholders seem aware of the risks affecting married women and do not include them in programming.[247]

It would therefore be helpful if questions could be added to the HRSS surveillance protocol to provide evidence on the extent to which marital fidelity is the statistical rather than only the ideal norm (e.g. questions on extramarital partners during lifetime of marriage, rather than just in last 12 months), on use of condoms with **regular** sex partner, and on the participation of **married** males and females in sex for gifts or money.

Other gender-relevant questions would be age-mixing in marriage, coercion at first sexual intercourse, and condom use by men who have sex with men as an important "bridge population" (female sex workers and their clients are already included). If the partner notification system for STIs and HIV is improved as suggested in Section 4.5, data on marital status and number of sexual partners could also be extracted from the records.

Information collected during NDOH/NAC's routine and sentinel surveillance of HIV/AIDS is presented in Quarterly Statistical Reports. However, there are weaknesses in the presentation that make it difficult to interpret trends relating to gender, and to infection in children. Bar graphs showing gross numbers of people infected by sex and age group (cumulative, and for the last quarter) are distorted by the inclusion of data from routine antenatal testing of younger women, in which males of course do not figure. The graphs imply that young women aged 15 to 24 are infected at several times the rate for young males, (and are often cited as such), [248] whereas the figures really reflect the much higher rate of females being routinely tested. Sero-prevalence studies of young men in the 15 to 24 year age group are needed for a meaningful comparison of infection rates in young men and young women.

A less misleading method would be to present data from antenatal testing separately from other sources (STI and TB clinics, and VCT centres), which should also be shown by sex and age group. The numbers and percentages on which the bar graphs for these key indices are based should also be presented in tabular form, so users may quote them. NACS and NDOH staff responsible for analysing the statistics should also be given training in gender sensitivity and gender analysis skills.

Anecdotal and research evidence suggests that young people and children (especially females) are at risk of HIV transmission through increasing rates of sexual abuse and exploitation.[249] Current surveillance does not capture this. The current breakdown of age-groups in the under-10s does not allow cases of perinatal transmission to be separated out from cases where sexual transmission is a likely cause.

Recommendations for consideration:

Expand surveillance to include factors affecting marriage as a protective institution for HIV/AIDS, disseminate this information to stakeholders involved in prevention and intervention particularly with women, and conduct sero-prevalence testing among young men aged 15-24 in the general population.

20. Improve the reporting of trends in the Quarterly Statistical Reports to more accurately reflect male-female differences and the factors affecting infection in children, and provide training in gender analysis for NACS/NDOH staff analysing the data.

[247] NHASP 2005 May, *Milestone 83, Social Mapping Summary Report,* p 20.
[248] E.g. UNDP 2005 June, *National Strategic Plan on HIV/AIDS of PNG 2004 –2008, A Gender Audit Report,*p 4 and 31-35, and UNAIDS 2004, *Fact Sheet on HIV/AIDs in Ocecania: UNAIDS Epidemic Update 23/11/04.* www.unaids.org
[249] UNCEF and HELP Resources 2005, *A Situational Analysis of Child Sexual Abuse and the Commercial Exploitation of Children in PNG,* Draft , January.

4.10 Stigma Reduction Through Appropriate Technology

Component 2's initiative of distributing "Living with Dignity Kits" (bucket toilet and water-saving shower, washing and laundry devices) has been found to help reduce the stigma of living with HIV/AIDS. The kits make it less unpleasant for a family sharing a house with an AIDS patient with continuous diarrhoea, reduce the workload for women, and allow patients to participate more in their own care (described in Section 2.4). The Goroka-based company which produced these, Appropriate Technology Ltd, has developed a number of other simple, low-cost items that could further reduce stigma and ease the burden of care, such as a canvas water-catchment and storage device, a washable plastic mattress cover, a fuel-efficient heating stove for colder mountainous climates, a portable shelter, a bush materials bed with moveable back-support and pulley, and a bush materials care centre with four bedrooms and a teaching room.

Stigma in clinical settings is partially linked to the lack of the materials for proper protection of health workers from the risk of HIV infection. Health workers are reluctant to give proper care to AIDS patients if there is no supply of rubber gloves, for example, and this applies also to their family care-givers, at home as well as in hospital. The mattress covers described above would be just as useful in health care facilities at very low cost (about K5 each), and absorbent pads for patients with diarrhoea would reduce the spoiling of bedding.

Recommendation for consideration:

21. Expand the use of appropriate technologies for the care of AIDS patients in home-based and health care settings, and ensure the regular supply of basic items necessary for disease control in both.

4.11 Peer Education

A peer education strategy for HIV/AIDS prevention was first used in PNG during the mid-nineties by the Transex Project working with men in transport-related occupations (truck and PMV drivers, shipping), police and security guards, and female sex workers. It was regarded as successful, and became a UNAIDS model of best practice.[250] Since then, numerous organizations have used a peer education approach, recognising that discussion of sexuality is most open when people are amongst their peers, with age and gender being the most significant factors. However, there is little agreement on other aspects, and there has been more competition than coordination and cooperation between organizations using the peer education concept

The European Union's Sexual Health Project, for example, has been piloting a national peer education programme for the last two years which has reached 10,000 people to date. To avoid confusion with their methods and approach, NHAPS's HRSS BCC programme has called its peer educators "BCCers", and the Poro Sapot Project, which took over from the Transex Project, has called its peer educators "outreach workers". NACS has a National Peer Education Advisor, whose role is to establish and monitor standards for peer education and develop training modules and oversee training. These tasks are still in progress, and it is not yet clear to what extent issues of gender inequality are being integrated. The EU's approach has a complete module on gender, gender violence and human rights, and is a promising model.

[250] UNAIDS 2000 November, *Female sex worker HIV prevention projects: Lessons learnt from PNG, India and Bangladesh.* UNAIDS Best Practice Collection.

Recommendation for consideration:

22. Hold a conference for all stakeholders using an approach based on peer education concepts to standardize approaches and ensure that issues of gender equality, gender violence and human rights are integrated into modules used with all peer groups.

4.12 Faith Based Organisations

Faith based organizations (FBOs) are active in HIV/AIDS awareness and prevention education, as well as in providing health care and VCT services. However, approaches used by many FBOs are problematic. Some are strongly opposed to the use of condoms, though there are signs that opposition is softening in some quarters.[251] Judgemental attitudes towards those who become infected with HIV or STIs predominate, though again there are signs of change, with the involvement of the leaders of the mainstream churches in plans for a 'Red Ribbon Ministry' in PNG, with 'continuity of compassion' from prevention through to care and support. All these leaders are male, and male dominance in the family remains a key theme underlying the approach, based on scriptural teachings about the roles of husbands and wives. This theme is even more prominent among fundamentalist sects, which are widespread in PNG. Homophobia, too, is prevalent.

One long-term observer of PNG society has concluded that "moralising … actively propels the epidemic".[252] Many examples of this were encountered during the consultations for this report. About half of PNG's health services are provided through FBOs, and VCT centres outside clinical settings are currently all church-run. There is also an impact on government-run sexual health services. Some health workers in government-run STI clinics not only refuse to give out condoms, but refuse information about them too, because they are "against the word of God". As one female health worker said: "When they ask about condoms, I tell them to think of their immortal souls".

However, there are ways in which FBOs can help promote more equal gender relations, for example by:

- taking a stand against violence in marriage and providing practical support (e.g. safe accommodation) to victims;
- challenging the sense of entitlement to control over women's bodies that brideprice legitimates for many men;
- promoting more open discussion of sexuality, and sex as a relationship-strengthener (if mutually pleasurable) rather than as a natural male appetite which demands regular satisfaction;
- challenging homophobia;
- promoting a more egalitarian, companionate form of marriage based on mutual responsibility rather than on male headship rights (an immediate concrete example would be for couples to sit together in church, rather than segregated by sex);
- encouraging shared parenting and sharing of the domestic workload.

As discussed in Section 3.3, moralizing about fidelity is not enough to protect married women from HIV infection, and can even increase their risk. Without a conscious effort to involve FBOs in more gender-sensitive approaches, it is likely that gender inequalities and moralizing attitudes will have an increasingly negative effect on women and girls. It would

[251] Rev. Kim Benton, NHASP STA on FBOs , personal communication.
[252] Eves R. 2005, *Moral Reform and Miraculous Cures,* p 19. Draft paper for forthcoming ANU publication on HIV/AIDS in PNG.

be helpful if technical support on gender could be provided by NHASP to NACS and FBO stakeholders to ensure that gender implications for HIV/AIDS are taken into account in FBO programme development on HIV/AIDS.

Recommendation for consideration:

1. Provide technical support in gender to NACS and FBO stakeholders to facilitate the development of gender-sensitive responses by FBOs to HIV/AIDS.

Annex 1
Adviser Terms of Reference

PNG National HIV/AIDS Support Project

Terms of Reference

Short Term Adviser: Gender Impact Evaluation

Project Background

Addressing gender in project activities entails consideration of gender relationships and the roles of both men and women. It is recognized that strategies designed to address inequities in gender will often challenge entrenched male power which can place women in very difficult or even dangerous situations.

NACS and NHASP have attempted to ensure that 'gender' is not just about women, but also about actively engaging men in the HIV/AIDS response. Experience has shown that implementing simple initiatives that are accessible developed in participation with and clearly communicated to counterparts and stakeholders, yields positive results in attaining gender equity awareness and action.

In 2004 there were significant achievements in the area of women and HIV culminating in World AIDS Day (WAD) activities focussing on the theme of Women and Girls and HIV. NACS and NHASP continue to work with UNIFEM and the National Council of Women to involve women in developing strategies and policies to achieve better outcomes for women. A follow up to the training of four men at the Fiji Women's Crisis Centre in 2003 was also undertaken.

NACS and NHASP continue to face numerous constraints to addressing gender in project activities. There are few women leaders in PNG society and a major difficulty remains with getting women in positions of leadership engaged in the response. Achieving equity in training is also difficult to achieve.

An evaluation of the project's approach to addressing gender is to be undertaken. This evaluation will provide insights into successful approaches and enable NACS to determine the most effective strategies for ongoing action. This evaluation will consider linkages with other donors, particularly UNDP, and how their ongoing program of support to gender and development can complement current initiatives.

The evaluation will also provide the requisite information for reporting to AusAID at the completion of the project. Guidelines to the reporting requirements can be found in AusGUIDElines 13: Preparing Completion Reports and 18: Promoting Practical Sustainability (Ref: http://www.ausaid.gov.au/ausguide/5stages/stage5/1.cfm).

Relevant Clauses in Scope of Services

This short-term consultant input pertains to completion of the Project Completion Report (Clause 15.12) and is related to the following output in the Project Scope of Services:

Output 7.4.2: Technical and resource support to facilitate monitoring of project / program activities

Purpose of Consultancy

The prime focus of this consultancy will be to provide an assessment of the differential gender impacts of the project activities and discuss the effectiveness of gender specific activities.

The adviser must be able to transfer knowledge and skills to counterpart staff and where appropriate contribute to the development of documentation that will be used for improvement of the current approaches to delivery.

Tasks

Review the constraints to enabling gender equity across project activities and promoting mainstreaming of gender equity with project partners.

Review project approaches to developing gender equity in its activities.

Examine the Project's approaches to building women's capacity to assume leadership roles in the response.

Outline strengths and weaknesses of project activity gender impacts.

Provide recommendations for future activities that build on the progress made and address specific areas of concern.

Outputs

1. Report detailing the evaluation process and findings. Report is to include a commentary on the Gender Impact Rating as outlined in AusGuidelines.

Schedule and Supervision of the Consultancy

A three week (21 day) input in PNG will commence in August 2005. The advisor will be based in Port Moresby but will travel to the provinces if required. The Gender Evaluation Adviser will work closely with the Australian Team Leader, the IEC and the Care and Counselling Adviser and liaise with the Project Director

Work schedules will be coordinated in conjunction with NACS counterparts and the Australian Team Leader. Any required travel and accommodation outside Port Moresby will be booked via the Project in accordance with agreed travel schedules.

Qualifications and Experience

The Adviser must be hold qualifications in social science or related disciplines and have experience with gender and development impact assessment. Previous experience in PNG or the Pacific is desirable.

Annex 2
Gender Framework Reporting Matrix

Annex 2: Gender Framework Reporting Matrix (2005)

COMPONENT 1					
Logframe Code	**Gender Strategy**	**Annual Plan Activities**	**Activity achievement**	**Indicator**	**Achievement**
1.4.1/ 1.4.3	Behaviour change programs and messages are relevant to social and cultural roles, traditions and expectations of men and women.	Social marketing and IEC development will include women's and men's focus groups.	Yes		
1.4.2	CBOs have skills, materials and networks to address gender, sexual violence and legal rights in their programs	Support given to women's/men's groups to educate women/men Gender and sexuality training incorporated into all IEC and behavioural change training programs	Yes Yes	Gender, sexuality incorporated in IEC materials and behaviour change training programs	Yes Both grant and component funding has been used to support gender specific activities.
1.1.3	Specific materials and programs to address needs vulnerability of women.	Women's groups included in strengthening of partner groups. School curriculum development will include gender specific sexual health issues. Promotion and distribution of female condoms	Yes Yes	Number of female condoms distributed	2002 - 17,000 2003 - 120,000 2004 - 238,000 2005 (Jan-June) 126,000
1.2.1/ 1.2.4/1.2.5/ 1.3/ 1.4/ 1.5.2	Community-based HIV/AIDS awareness program addresses gender issues and sexual power	Further research on the BCC needs of MSM and male and female sex workers (Grant) Gender issues addressed in national and provincial materials. Training packages for partners will include in this period the National Council of Women. (Grant) Community Action Participation (CAP program) awareness and distribution of female condoms. Participation of this component in the High Risk Settings strategy (C7) Stigma reduction materials for use at the community level include gender specific issues relating to discrimination	In progress Yes Yes Yes Yes	Gender specific issues incorporated into stigma reduction materials	Yes (pending in July-December) December 2004 - women and violence materials developed and a mini campaign undertaken for radio and TV. Coincided with International Women's Day 2004. A one- week training program was run for provincial women leaders in July 2004 with follow up grant funded provincial activities. Research conducted by Save the Children and IMR on sex workers-funded and/or supported by the project.

1.4/ 7.6	Targeted interventions identified and supported to address specific high-risk behaviour among men and women.	Focused BCC (and enabling environments) directed to high risk male settings in this period such as prisons, police, military, mining and logging sites, etc. SMS and sex workers (male and female) targeted through grants program.	In progress In progress	Number of women/men included in targeted interventions	Grant funds to Save the Children for work with sex workers. HRSS addressing male sexual behaviour in the military. Component 4 has conducted a survey of sexual behaviour of male prisoners at Bomana Prisan (381pp) and of male soldiers at Taurama Barracks (181pp) in Q 19.
	CBOs with programs addressing male violence, alcohol usage, literacy and income generation have skills and materials to address HIV/AIDS issues	Generic HIV/AIDS materials available to CBOs	Support to CBOs addressing these issues.		CBOs funded through grants. Women and violence materials available for community groups.
1.7	Other	Target women leaders as well as men to develop political commitment for HIV/AIDS	Yes	Number of women/men involved in advocacy strategy for high level political commitment	Leadership training for women planned for October 2005. Dame Carol Kidu, Minister of Social Development, is being supported to progress the decrimininalisation of sex workers legislation.
COMPONENT 2					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity achievement**	**Indicator**	**Achievement**
2.1.3/2.3	Counsellors and carers trained in dealing with the realities of violence, lack of rights and control in sexual relationships.	Gender issues and gender violence integrated into all training and counselling and care delivery	Yes	Gender and sexuality incorporated in all counselling and care curricula	Yes
2.2	Greater participation of men in home based care.	Men encouraged to participate in training and delivery of home based care	Yes	Gender disaggregated data on counselling and home care training	This is a new training for the project TOT for HBC: Jan-August 2005 (M 12 F 31) Trained by the Trainers: Jan-August: (M 55/F 73) 85 of these people are health workers.
2.2/2.2.3/2.2.4/2.2.6	Specific and reliable counselling services	Health workers including those at ANC and MCH clinics will continue	Yes	% of ANC counsellors (women/men) given training	Training for VCT counselling and rapid testing is being undertaken.

	available for women testing HIV-positive at antenatal clinics.	to be trained in counselling and VCT The roll out of VCT will cover ante natal clinics as ART becomes available for pregnant women.			
2.3.6	HIV/AIDS counsellors have skills, materials and networks to address violence and crisis counselling.	Training and resource materials addressing gender issues and gender violence continue to be developed with C1	Yes	% of training and resource materials addressing gender and gender related violence	All training materials contain sessions on gender and participants are challenged to consider the link between gender and HIV New HBC training includes gender issues.
2.3.5 with C5	Health workers have skills and knowledge to support victims of sexual violence	C2 and C5 work together to train health workers in counselling including dealing with gender violence	Yes	% of health workers who have undergone counselling training including dealing with gender violence	Jan-August 2005 - Health Workers (M 155/F 197) trained in gender issues (including Gender violence). This training is on going
2.3.5 with C5	Counsellors competent to address the specific health care needs of women living with HIV/AIDS	The advanced C&C course also includes teachers and social/development workers	Yes	No of counsellors trained in addressing the health care needs of women living with HIV/AIDS	January-August 2005 – M 155/F 197 trained in the care of women living with HIV
2.1	Other: Gender violence	Men's peer education strategy for gender violence	Yes		7 men have been sent for male advocacy training through the Fiji Women's Crisis Centre in 2004. These men now contribute to Care and Counselling training programs.
COMPONENT 3					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity Achievement**	**Indicator**	**Achievement**
3.2.1	Sectoral Response Advisory Committee understands Gender and HIV/AIDS issues, and has the capacity to incorporate these into sectoral policies and programs.	Gender training for NACs staff Women's interests represented in the planning and implementation of the NSP	Yes Yes but not as well as they should be.	Number of NACS staff who have been trained in gender and HIV	Gender issues not adequately represented in the NSP but some issues addressed. NACS staff included in all trainings, e.g., Burnet Course in 2005 which included engaging with gender issues.
3.2.2/3.2.3/3.2.4/ 3.3.4/3.4.2/3.4.4	Sectoral mainstreaming of HIV/AIDS addresses gender issues in the development of HIV/AIDS policy and	NSP reviewed for gender impact before being finalized. Sector specific policies will address gender issues. Worksite policies	Yes Yes Yes		Gender issues included in trainings for worksite policies and mostly reflected in sector policies. Project has input into the L&J Gender policy to include women and HIV

	programs	address gender issues. Materials being developed in this period to explain consumers' sexual rights will include Women's Sexual Rights.			issues.
3.1.6	Advocacy to raise awareness of the impact of laws against sex workers and male to male sex.	Review of current laws will examine the feasibility of decriminalizing sex work. Follow up training and public information materials	Yes Yes		Paper prepared on feasibility of decriminalising sex work
COMPONENT 4					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity Achievement**	**Indicator**	**Achievement**
4.4	Surveillance addresses contextual social and cultural factors that shape sexual behaviour.	This period will see the commencement of behavioural surveillance which will document gender specific sexual practices obtained through surveys. IMR through grants also looking at gender specific sexual practice and the contexts shaping sexual behaviour. Surveillance to include both men and women.	In progress at PMGH In progress Yes	Gender disaggregated surveillance data	Passive surveillance data is gender disaggregated. Active surveillance data has for the first time in 2004 been reported by gender
2.2.4/2.2.6 1.5.2/1.5.3	Surveillance does not lead to blaming of female populations.	The increased availability of VCT in this period will provide more support to people found to be HIV positive including women at antenatal clinic sites. Anti stigma campaign run in this period including community component.	Yes (no data available) In July-December		All the ground work has been completed for a major roll out of VCT. This will increase the access to testing and counselling support for both men and women.
4.1	Surveillance addresses all gender groups	Extended coverage will increase access to testing for both men and women.			Coverage of surveillance increased from 14 surveillance sites to 22.
COMPONENT 5					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity Achievement**	**Indicator**	**Achievement**
1.2/1.5.3/1.5.4	Health workers have skills, competence and supplies to provide sexual health IEC information and advice on	General STI training and resource materials, including gender issues, are being further developed in this period. Education re female condom use plus female	Yes Yes	HW training curriculum includes gender and female controlled prevention methods	Yes

	female controlled prevention methods.	condoms distributed.			
5.1.1/5.2.2	Equal access by men and women to STI clinical care.	A limited number of gender specific facilities exist. It is hoped that these will be expanded in this period thus increasing access to private, confidential and gender specific services.	Yes	Gender ratio of STI clinic staff (outcome indicator)	13 provinces have gender specific staff. As new STI clinics are built this number will increase as the MOUs require gender specific staffing. No change in 2005 as no new clinics built.
5.7.2/5.7.3/ 5.7.4/5.7.5/5.7.6/ 5.7.7/5.7.8/52.5	Health workers have skills and knowledge to support victims of sexual violence.	Components 2 and 5 are working together to strengthen the capacity of health workers to deal with gender related violence and other gender issues.	Yes	% of women/men HWs trained in HIV counselling	Training is being carried out on gender and gender violence through the health sector
	Health workers competent in addressing specific health care needs of women living with HIV/AIDS.	As above			
COMPONENT 6					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity Achievement**	**Indicator**	**Achievement**
6.3/6.5	NAC, NACS, PACs and NAC sub-committee members understand gender issues.	Under the grants program and in consultation with UNIFEM and UNDP, it is proposed to run further programs in Gender and HIV/AIDS for NACS and provincial staff	Programmes conducted in 2004 for International Women's Day	Number of staff trained in gender and HIV	30 provincial women leaders trained in HIV and gender by the end of 2004. A further 30 national women leaders to be trained in 2005. Gender included in all PAC training. NACS staff trained in gender through Burnet Course in 2005.
6.3.3/6.3.5/ 6.5.3	HIV Response Coordinators (HRCs) have knowledge and understanding of gender issues.	Induction programs will deal with stigma and gender issues The short term HRD and TNA advisers will be asked to address gender issues in their recommendations.	Yes Pending in July-December	Gender and HIV addressed in induction and other training for HRCs.	Gender included in all PACS training.
6.4	HRCs and Provincial Counselling Coordinators have equal status and salary.	This has not been achieved at this stage. It is an issue which could be included in the TORs for the Review of NACS.			The number of HRCs who are women has only increased from 2 to 4 in the last year. T he disparity in status and pay remains.
COMPONENT 7					
Logframe code	**Gender Strategy**	**Annual Plan Activities**	**Activity Achievement**	**Indicator**	**Achievement**
7.1.4/7.2.4	Ensure equal access of men and women to	Built into the new guidelines and monitored through	In the Guidelines	Gender disaggregation of grant	Monitoring reports are including this data.

	project grant system.	analysis of funded projects		beneficiaries	
	Ensure process in place for assessing gender sensitivity of grant applications.	The principles to which applicants agree includes a statement on access for women	In the Guidelines		Gender issues considered in appraising grant applications.

Gender Story from a HBC Workshop

In reviewing the training and draft materials after the trial HBC workshops, one of the female trainers made a comment on the inclusion of human rights and gender material in the manual. The training held in a remote part of Enga province contained a range of participants many of whom were men. The woman trainer, herself a highlander was shocked at the living conditions of the women in the village, housed in the same house as the pigs. Throughout the training the men were challenged as they heard for the first time about human rights and the inherent value of a woman. At the end of the workshop the men were very remorseful about the way they had treated women in the past. Since the workshop the PCC has noticed one of the participants who had previously never been seen in public with his wife now regularly goes to the market with her. The PCC asked about the change to the man who said that "I never knew before that my wife is an important person"

Annex 3
Persons Consulted

Annex 3: Persons Consulted

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Baua Baua Theatre group members, Wewak (3m, 4f)		
7 Madang Provincial Council of Women Peer Educators		
Yabob Villagers, Madang (9m, 15 f)		
Madang receipient of NHASP training (8f, 16m)		
NHASP trainers (9m, 11f)		
24 stakeholders trained by NHASP (16m, 8f)		
24 Eastern Highlands women's leaders, Goroka		
Participants at New Guinea Island and Southern Region PAC Training Workshops (43m, 26f)		

Annex 4

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Zimmer-Tamakoshi L. 1997, *Wild Pigs and Dog Men: Rape and Domestic Violence as "Women's Issues" in Papua New Guinea.* In Brettell C. and Sargent C. ed.s, ***Gender in Cross-cultural Perspective.*** Upper River: Prentice Hall, 2nd edition, pp538-553.

Useful Websites:

UNIFEM's Electronic Library on Gender and HIV/AIDS:
www.genderandaids.org

This is the most comprehensive and user-friendly resource. It is also available free from UNIFEM as a CDROM.

Global Coalition on Women and AIDS: www.womenandaids.unaids.org

UNAIDS (Joint UN Programme on HIV/AIDS: www.unaids.org/gender

WHO: www.who.int/gender/hiv_aids

Interagency Coalition on AIDS and Development: www.icad-cisd.com

Gender-AIDS Forum: archives.healthdev/net/gender-aids/

International Centre for Research on Women: www.icrw.org

INSTRAW on men and gender violence:
http://www.un-instraw.org/en/index/php?option=content&task=blogcategory&id=119&itemid=183

South African Microfinance, HIV/AIDS and Gender Equity Project:
http://www.wits.ac.za/radar/IMAGE_study.htm Includes manuals, and evaluation tools.

Draft guidelines for health sector responses to rape can be found at
http://www.wits.ac.za/radar/Gender_and_HIV.htm

WHO guideline document for medico-legal care for victims of sexual violence can be found at:
http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

Annex 5
Approaches to GBV Prevention

Annex 5: Potentially promising approaches to GBV prevention and typical pitfalls/problematic approaches by sector.[253]

Potentially promising approaches	Typical pitfalls and problematic approaches
JUSTICE	
Pressure on governments to comply with international human rights agreements	Failure to allocate resources for implementing new laws and policies
Educating law enforcement and the public about new laws	Failure to monitor and evaluate implementation or impact of laws/policies
Broad investment in strengthening law enforcement approaches to GBV (protocols, training, etc)	Under-investment in police and courts
Long-term efforts to educate police-judiciary on the implications of GBV	Family courts that require survivors to attempt reconciliation with abusers
Specific GBV related legal reforms (special stations, cells or courts etc.)	Separate women's police stations without broader law enforcement reforms
Comprehensive medico-legal system reform (e.g. forensic nursing)	Policies restricting collection of legal evidence to forensic physicians
Networks and alliances between legal, social and health organisations	Failure of law enforcement to co-ordinate with social and medical services
Efforts to publicize enforcement of laws that protect women's rights	Lack of legal aid services for divorce and child support
Reform of informal justice systems (e.g. traditional courts and councils)	Practices that allow traditional authorities to block women's access to courts
HEALTH	
Policies facilitating access to emergency contraception, STI/HIV prophylaxis and safe abortion	Government mandates without allocated funding
Policies clarifying providers' roles and responsibilities in cases of GBV	Mandatory reporting requirements for adult survivors of GBV
Broad institutional reforms to improve health care response to GBV	Routine screening for GBV without broader institutional reforms
Networks and coalitions for research, referrals, advocacy and education	Failure of health sector to co-ordinate with other community services
Community education that aims to improve awareness, knowledge, attitudes, behaviours, and access to services related to GBV as a public health problem	Health education programs that lack a human rights framework
Reproductive/HIV education for youth that addresses gender and GBV	Reproductive health programmes that fail to address gender or sexual coercion
Mass media "entertainment-education" programmes	Campaigns that use "macho" imagery (e.g. for condom promotion)
EDUCATION	
Implementation and enforcement of sexual harassment laws and policies	Vague, unenforced or non-existent national sexual harassment policies
Improved school infrastructure (more rural schools; more female teachers; safe, working latrines for girls	Schools that ignore parents' concerns about girls' safety
The "whole school" approach to educator training about GBV	Educator training limited to a single session, or of poor quality
School-based counselling and referrals	Schools without links to external GBV services
School-based programmes focussed on changing male gender norms	Abuse prevention programmes focussed solely on girls
School-based sexual and reproductive health programmes that encourage a critical consciousness about gender and violence	School-base health education focussed primarily on anatomy

[253] Adapted from Bott S., Morrison A. and Ellsberg M. 2005 June, *Preventing and responding to gender-based violence in middle and low-income countries: a global review and analysis.* World Bank Policy Research Working Paper 3618, p 44.

MULTI-SECTORAL	
Laws/policies to enhance women's ability to exercise economic rights	Policies that restrict women's economic rights or privilege men's access to economic opportunities
National Plans for a comprehensive approach to GBV	Inadequately funded, implemented or evaluated national GBV plans
Networks and coalitions for expanding social services	Lack of investment in social services; lack of co-ordination
Micro-credit and income-generating programmes that integrate attention to GBV	Micro-credit institutions that ignore the implications of GBV
Multi-sectoral approaches to GBV services for refugee women and girls	Poorly designed refugee camps (e.g. poorly planned lighting, security, male controlled distribution systems and location of water and firewood)
Attention to women's needs and priorities in transport/infrastructure projects	Transport and infrastructure projects aimed solely at men's priorities
Community mobilization and mass media campaigns to change attitudes and increase access to social services	

Annex 6

Gender Audit of the National Strategic Plan: Implications for NHASP

Annex 6: Gender Audit of the National Strategic Plan: Implications for NHASP

The numbered recommendations relate to Focus Areas of the NSP and are taken from the UNDP-sponsored Gender Audit of the Plan (UNDP 2005, July).
'R' refers to recommendations made in the body of this Report. 'C' refers to the NHASP component concerned.

Focus Area 1: Treatment Counselling Care and Support	**Implications for NHASP**
1.1 Disaggregate beneficiaries/target groups into more relevant and intervention specific categories at the strategy levels.	Already implemented in C1 and C2. Relevant for district/provincial strategic planning and HRSS.
1.2 Specify inclusion of health workers by the kind of gender based services they offer to ensure women and especially adolescent girls will be adequately covered in health settings.	Already considered by C5, though not yet for adolescent girls' needs.
1.3 Set sex specific national targets for ARV treatment.	C5 to consider.
1.4 Include women both as pregnant women and women outside their reproductive role for treatment interventions and set targets accordingly.	Already covered by NDOH Protocol, Jan. 2005.
Build ARV treatment literacy among both the vulnerable sections and health workers to ensure women, female sex workers, MSM, all have the knowledge about treatment options.	C1 and C5 to liaise with Global Fund.
Develop protocols for use in VCT that address the potential risks and negative consequences for women, and boys and girls.	See R14, for C2.
1.7 Train VCT staff to respect the rights of users, especially pregnant women, to refuse HIV test	Already covered in C2 and C5 training.
1.1 Assure VCT locations are safe for use by vulnerable populations especially younger men and women and adolescent girls by locating them with general programs such as, life skills development programs	C2 and C5 to consider.
1.9 Encourage couple counselling to safeguard partners from the vicious cycle of denial and blame	See R14, for C2 and C5.
1.2 Place gender in the center of the HBC strategy such that women care givers are acknowledged and not exploited and men are not merely the benefactors but also care providers.	Already done by C2.
1.11 Ensure a gender and age mix of care providers in the program.	Already being done by C2, though young people not yet involved enough.
1.12 Give due recognition to the needs of women	Women's needs recognised, but not

as primary care givers in homes and ensure that their needs for counselling, resources, information, finance and emotional support are properly assessed and met.	yet fully met, see Rs 7 and 21.
1.13 Ensure that families of both men and women living with HIV/AIDS are included for HBC program.	Already being addressed by C2.
1.14 Assess the cost of home based care giving using the feminist framework of 'care economy' and integrate the findings in revising the HBC approach in future.	Suggest to C2, for possible funded research under the Grants Programme (C7)
1.15 Involve men too in the affected families in care giving by challenging traditional gender roles and seeking to transform them.	Already being done by C2.
1.16 Provide economic assistance to families enrolled in the HBC to alleviate the economic burden of long term care.	Suggest to CSOs.
1.17 Ensure that school age girls in the families enrolled for HBC program are not withdrawn from school and do not suffer neglect because of older female members' involvement in care.	See R7
1.18 Ensure that HIV positive women are equally benefited by the HBC not just through assistance in their care-giving role for HIV positive male partners but also as recipients of care and support when they fall sick and are in need of care.	No evidence yet available on this. C2 to evaluate with stakeholders.
Specify that both male and female health staff will be put in place in all STI clinics with adequate privacy for ensuring confidentiality.	In progress since 2002, in C5.
1.20 Train health workers in the diagnosis/treatment of a range of STIs, including non-symptomatic STIs among women and oral STIs among those engaging in anal/oral sex and develop appropriate protocols.	In progress since 2003, in C5, though more focus on oral STIs needed.
1.21 Orient the health workers to gender issues and build their capacity for a sensitive, non-judgemental approach in treatment of STIs.	In progress since 2003 in C5, but highly judgemental attitudes are still very common, especially in FBO-run services. See R23
Focus Area 2: Epidemiology and Surveillance	
Develop 100% accuracy in collecting data for the most basic variables of age/sex.	Being addressed by C4.
2.2 Specify sentinel sites with their potential to represent all the major high risk groups and the general population to ensure a gender informed epidemiological profile for the country.	Being addressed by C4.

2.3 Orient the data collection/surveillance staff to gender issues and impart training in collecting gender sensitive data.	IMR researchers contracted by NHASP to do sero and behavioural already gender sensitized. See R20 for C4.
Focus Area 3: Leadership, Partnership and Co-ordination	
3.1 Elicit a more active participation of women leaders from provincial/ village level local bodies.	See R17
3.2 Build alliances with gender sensitive and gender aware prominent writers, academics, journalists, researchers, and other public figures and opinion makers.	See Rs 2 and 17
3.3 Build leadership from the corporate, entertainment and sports sectors to reach out to adolescents and younger men and women.	Being done by C1 and C2, but more needs to done, especially with adolescents and young women. See R17.
3.4 Put in place a gender specific budget plan.	Not necessary: because the epidemic is heterosexually driven, prevention programmes for men benefit women, and vice versa. For care and support, quality is as much an issue as quantity.
3.5 Demonstrate commitment to GIPA by acknowledging the PLHA, men and women, as leaders for change and advocacy.	Being done, in partnership with UNDP, but could be further strengthened, especially in C1, C2, C6 and HRSS.
3.6 Support the creation of a women's unit within the PLHA group for more gender based advocacy, care and support interventions.	Not necessary, as women already predominate.
Focus Area 4: Monitoring and Evaluation	
Develop appropriate gender sensitive indicators to measure the impact of the national response and track the progress of the epidemic.	Included in HRSS, and see Rs 13 and 19.
4.2 Incorporate gender into the process, outcome and impact evaluations.	Already addressed through Milestone 36 and this Report, and annual M & E.
4.3 Evaluate the NSP by gender and age based indicators.	N/A
4.4 Monitor resource allocation to programs to ensure gender equity in distribution.	See comment for 3.4
Focus Area 5: Education and Prevention	
1.1 Develop and support activities that seek to transform gender norms and relations in society as the key approach.	See Rs 3,4,5,6,7,10, 11, 12, 13, 15, 16, 17, 18, 22, 23.
1.2 Support the use of information channels that are uniformly available to men, women, boys and girls, in rural areas and to illiterate populations.	See Rs 12 and 22. Much more emphasis on rural outreach is needed in C1.

5.3 Make all information material gender sensitive, particularly avoiding gender stereotyping, e.g. men in dominant provider role or women as victims.	See Rs 8, 13, 22 and 23.
1.1 Examine the existing education and prevention approaches, for example the ABC approach, from a gender perspective to understand how gender operates in the interpretation and adoption of health messages.	See Rs 3, 8, 12 and 13.
5.5 Develop gender sensitive BCC programs based on the understanding of contextual factors for specific groups: male clients of sex workers, migrant and mobile populations, mining workers, adolescent girls and boys, professionals, and so on.	See Rs 8, 12 and 13.
5.6 Develop education programs that address basic and gender biased misconceptions in relation to HIV/AIDS.	Being done in C1, C2 and C6, but more needed. See R10.
1.1 Develop education programs to address gender and sexuality, and to fill gaps in knowledge on reproductive and sexual health of all groups including men.	See Rs 6 and 18.
5.8 Develop strategies and education programs to raise public awareness about issues like cross generational sex, domestic and sexual violence, and the harmful and negative consequences of certain cultural and traditional practices in regard to HIV.	See Rs 4, 5, 6, 8, 11, 13, 19, 22 and 23.
5.9 Specify target groups under all interventions by sex and age to ensure gender sensitive programming.	See Rs 3, 12 and 13.
Develop programs for promoting female controlled methods of safer sex.	See R16
Promote condoms as dual protection device.	See R16
Focus Area 6: Family and Community Support	
Develop a supportive environment for PLHA to disclose their sero status and serve as advocates by developing mechanisms for the protection of their rights to treatment , care, information and right to earn and for addressing stigma and discrimination.	HAMP Act already in place. Igat Hope is PLHA support and advocacy group. See Rs 13 and 21 re stigma reduction.
6.2 Incorporate the HBC strategy with programs on income generation (micro credit programs) and food security to support HIV infected and affected households with no income.	See R7
6.3 Develop programs to sensitise communities about gender and HIV vulnerability issues.	See R22.
Involve men in the care of positive family members through the HBC program.	Already being done through C2. See also Rs 6 and 18.

6.5 Conduct gender specific needs assessment among PLHA and other vulnerable populations to assess gaps in services	Already done by C2, in conjunction with Appropriate Technology Ltd. Recommend further action to UNDP Sexual Health Project.
6.6 Assess the information, education and counseling needs of communities involved in support initiatives for infected and affected populations	To be done by C2.
6.7 Adopt a gender and rights based approach in all HIV related interventions and programs	Already adopted by NHASP since the outset, but not effectively yet by NACS.
Address gender disparities in customary laws and practices through reviews and reforms in laws of property and inheritance and family laws in relation to HIV/AIDS	C7 to liaise with the LJSP. See also R7.
Recognise and address the vulnerabilty of co-wives to HIV in customary polygamous relationships and address issues like lack of rights of co-wives to claims in property and employee benefits	As above.
6.10 Estimate OVC by sex and age to address their needs in gender specific ways	C7 to liaise with UNICEF on this.
Focus Area 7: Social and Behavioural Research	
Build capacities of national researchers to carry out gender focused research through both quantitative and qualitative research approaches	Already being done by Social Mapping training, and the IMR for its sero and behavioural surveillance.
Promote research on gender and sexuality to examine norms of masculinity and femininity, culture of sexual violence, risk taking in sexual behavior, sexual relationships and couple communication, notions of healthy sex, sexual desire and pleasure seeking, to name few areas	Already addressed by NHASP's STA on Research. See also R6.
7.3 Promote research on men, adolescent girls and young women, MSM and other bridge populations such as mobile men	See Rs 6 and 13.
1.1 Conduct gender specific needs assessment of PLHA	See 6.5.
1.2 Assess the socio economic impact of the epidemic on men, women, households and communities and particularly the issue of care economy	C7 to discuss with AusAID and the STA on Research.
7.6 Document and analyse the issue of AIDS related stigma and discrimination and the gender dimension of the problem in PNG	Stigma and gender indicators already included in annual Marketsearch surveys. Forward planning on this needed by C1.
Develop research proposal guidelines to promote gender sensitive research design and adopt selection criteria for NGOs/interventions to	C7 to discuss with the STA on Research.

	support organisations that are gender sensitive and possess capacity for gender analysis and planning	

Annex 7

UNAIDS Gender Sensitivity Checklist

Gender & AIDS

Gender Sensitivity Checklist

The aim of this checklist is to provide HIV/AIDS educators and policy makers with a tool to assess the gender sensitivity of their programmes and policies. Assessing gender sensitivity allows one to see if programmes, policies, and/or organisations are identifying and catering to the needs of all genders. Gender sensitivity is an important concept, especially in HIV/AIDS prevention. As programmes and policies become more gender-focused, the potential for effectiveness increases due to the inclusion of the needs of all participants.

This checklist can be used in the development of an HIV/AIDS programme or policy to promote the adequate inclusion of gender components. It can also be used to assess and to modify existing HIV/AIDS programmes or policies to include gender sensitivity concepts and activities. In addition, this checklist includes questions relating to the gender sensitivity of individual organisations that implement these programmes and policies. These three areas have been included in this checklist in an effort to facilitate a gender focus at all levels of HIV/AIDS prevention. Such a focus will give women, men, girls and boys greater representation in all aspects of HIV/AIDS prevention efforts.

Each item on this checklist is to be implemented, whenever possible, with the involvement of women, men, girls, and boys. Such involvement will help facilitate their inclusion in the development and implementation processes. Please adapt the items on this checklist to fit the social and cultural needs of specific participants, programmes/policies, and/or organisations.

The term "gender" is used to describe the various characteristics assigned to women and men by a given society. The term "sex" refers to biological characteristics. Gender is socially constructed, learned, and can vary from culture to culture, generation to generation, and over time due to societal changes. Gender roles reflect the behaviours and relationships that societies believe are appropriate for an individual based on his or her sex.

Summary:

This checklist has been compiled to provide individuals involved in HIV/AIDS prevention programmes and policies with a tool to assess whether their work is sensitive to the needs of women, men, girls, and boys. The checklist can be used in the development and/or implementation of an HIV/AIDS prevention programme or policy. In addition, the checklist can be used to assess the gender sensitivity of organisations that implement such programmes and policies. The Gender Sensitivity Checklist is a component of the *UNAIDS Resource Packet on Gender & AIDS*, which includes additional modules, fact sheets and an almanac.

Goal:

To provide HIV/AIDS educators, policy makers, and sponsoring organisations with a tool to assess the gender sensitivity of their work.

Intended Audience:

Programme/Policy Developers

Health Educators

Sponsoring Organisation Staff Members

Gender Sensitivity Checklist

Please take a few minutes to complete the checklist. The list can be used as a guide to provide ideas on how to enhance existing programmes/policies as well as to assess the sensitivity of programmes/policies. A response of "yes" to every item on this checklist is not needed in order to consider your programme or policy gender-sensitive. Once the checklist is completed, look over your answers to see how you might include more gender-sensitive components to enhance your programme or policy.

Programme/Policy Development

Does your programme/policy . . .

Yes	No	
☐	☐	encourage community members, especially women and girls, to participate in the development planning process?
☐	☐	use innovative and nontraditional means to solicit the participation of community members, especially women and girls, in the development planning process? (For example, hold planning sessions where women traditionally gather, provide services to women so they can forgo their daily tasks in order to participate, etc.)
☐	☐	encourage community groups, especially women's groups, to participate in the development planning process?
☐	☐	encourage people living with HIV/AIDS, especially women and girls, to participate in the development planning process?
☐	☐	include all participants, especially women and girls, in the development of programme/policy goals and objectives?
☐	☐	provide gender training for programme facilitators?
☐	☐	include facilitators who are members of the programme target population?
☐	☐	include facilitators who are comfortable with discussing gender sensitive issues?
☐	☐	tailor activities to the particular economic, political, and cultural realities of participants?
☐	☐	tailor activities to address the power imbalances between women and men and between girls and boys?
☐	☐	include participatory activities (group activities, role playing, brainstorming, mapping, story telling, etc.)?
☐	☐	produce educational materials that promote positive representations of women, men, girls, and boys, as well as people living with HIV/AIDS?
☐	☐	occur at a time and place that is convenient to all participants, especially women and girls?
☐	☐	provide transportation for participants in an effort to encourage attendance?
☐	☐	provide child-care for participants during programme activities?

Programme/Policy Implementation

Does your programme/policy . .

Yes	No	
☐	☐	encourage community members, especially women and girls, to participate in peer education? (For example, leading segments of the workshop discussions, demonstrating condom use, etc.)
☐	☐	encourage people living with HIV/AIDS, especially women and girls, to participate in the programme implementation?
☐	☐	provide access to information and knowledge about HIV/AIDS to all participants equally?
☐	☐	encourage discussion about socially assigned gender roles affecting women, men, adolescents, and the elderly?
☐	☐	enable women and men, and girls and boys to understand one another's needs?

Yes	No	
☐	☐	attempt to ensure that women and men, and girls and boys are listening to the needs of one another? (For example, have participants represent one another in role play, have participants summarise and repeat the issues raised in discussion, etc.)
☐	☐	encourage discussion of the various social factors, such as economics, politics, and social structure that put women or men more at risk for HIV/AIDS?
☐	☐	encourage discussion of the biological factors that put women or men more at risk for HIV/AIDS?
☐	☐	encourage discussion of how gender inequality affects HIV/AIDS prevention, transmission, treatment, and care?
☐	☐	address the financial difficulties brought on by HIV/AIDS, which often disproportionately affect women and girls? (For example, laws which do not allow women to inherit land from their husbands, the need for widows to seek out new forms of income to support their families, the burden of health care costs which often become the responsibility of women, etc.)
☐	☐	encourage discussion of the power imbalances between women and men and between girls and boys and how these imbalances affect the transmission and prevention of HIV/AIDS? (For example, the difficulties women face in insisting that their partners use condoms, the ability to choose when and with whom to have sex, etc.)
☐	☐	encourage discussion of how empowerment of women and girls could help lessen their vulnerability to HIV/AIDS? (It is crucial to include men and boys in this discussion so they can participate and support their wives, sisters, and mothers as opposed to becoming threatened by their empowerment.)
☐	☐	work to eliminate the power imbalances between women and men and between girls and boys?
☐	☐	address the issue of violence against women and girls?

Yes	No	
☐	☐	provide opportunities for women and girls to become empowered through HIV/AIDS education? (For example, enhance the self-confidence of women and girls by encouraging them to attain new skills, take on more responsibilities as desired, become local leaders in health promotion, etc.)
☐	☐	encourage and acknowledge the support that women and girls can provide to one another?
☐	☐	encourage equal communication among participants about sexuality, sexual health, and sex practices (dry sex, anal sex, sex with commercial sex workers, etc.)?
☐	☐	address the double standard that exists between women and men in relation to sexual activity? (For example, men being allowed to engage in sex outside of marriage while women are not, men being expected to have sexual experience before marriage while women are not, etc.)
☐	☐	address the issue of sexual abuse (rape, incest, etc.)?
☐	☐	address adolescent sexuality and the effect it may have on HIV/AIDS?
☐	☐	address the importance of equal assess to education for both girls and boys?
☐	☐	address the reproductive and sexual health needs of children and adolescents?
☐	☐	facilitate awareness in adults of the reproductive and sexual health needs of children and adolescents?
☐	☐	encourage adults to address the reproductive and sexual health needs of children and adolescents?
☐	☐	provide demonstrations to all participants on how to use both male and female condoms and encourage all participants to practice their use?
☐	☐	encourage discussion about the possible difficulties associated with condom use experienced by both women and men?
☐	☐	address how HIV/AIDS affects how women and men make reproductive choices?
☐	☐	encourage the involvement of both women and men in family planning?

Gender Sensitivity Checklist

Yes No

- ☐ ☐ address how to avoid HIV transmission from mother to child (both before and after birth)?
- ☐ ☐ address the need to improve the quality of health services for women and girls?
- ☐ ☐ address the need to improve access to health services for women and girls (transportation, financial, etc.)?
- ☐ ☐ address the various health care changes that occur over a lifetime and how those changes affect HIV/AIDS treatment and prevention? (For example, a woman's health needs and HIV/AIDS susceptibility may change significantly as her body changes through adolescence, child-bearing years, and menopause.)
- ☐ ☐ encourage men and boys to participate equally in HIV/AIDS prevention efforts?
- ☐ ☐ encourage men and boys to help with domestic tasks as women's lives are impacted by HIV? (Greater assistance with domestic tasks may be needed if a mother, sister, or wife becomes ill, if she has to care for infected loved ones, if she has to begin to generate the family income, etc.)
- ☐ ☐ encourage men to become more involved in the care of their families?

Organisational Structure

This section has been included to enforce the fact that not only should programmes/policies reflect gender sensitivity, but so should the organisations which implement such programmes/policies. Gender awareness throughout an implementing organisation can benefit staff as well as programme/policy participants. Staff will be more invested in the concept of gender sensitivity and will convey more successfully and convincingly the importance of gender sensitivity in their HIV/AIDS prevention work.

Does your organisation . . .

Yes No

- ☐ ☐ have stated policies that affirm a commitment to gender awareness (goals and objectives, mission statement, etc.)?

Yes No

- ☐ ☐ encourage and support participation among women and men in practices and activities? (For example, do both women and men have an opportunity to participate in discussions, to manage and develop programmes/projects, to hold advisory positions, to participate equally in planning and implementation of services, etc.)
- ☐ ☐ monitor internal practices in an effort to identify areas that are not currently gender sensitive?
- ☐ ☐ continually adapt internal practices in an effort to remain gender sensitive?
- ☐ ☐ support gender awareness among staff? (For example, provide gender sensitivity training to staff members at all levels.)
- ☐ ☐ have ideas of gender sensitivity formalised at all levels? (For example, include gender sensitive practices from entry level positions through top management level.)
- ☐ ☐ employ both women and men?
- ☐ ☐ provide women access to a variety of positions at all employment levels?
- ☐ ☐ pay women and men the same for equal work?
- ☐ ☐ support the needs of employees, both women and men, with families? (For example, provide childcare facilities, allow employees to work flexible schedules, provide leave to care for loved ones, etc.)
- ☐ ☐ provide both women and men access to training activities and extension services to facilitate professional development?

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